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THE EMOTIONAL RESPONSE TO TUMORS OF THE BREAST

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Case reports illustrating the effect of emotions on the course of medical illness appeared in the ancient literature. One of the earliest reported cases involves Democedes, who is described as being one of the most successful physicians of antiquity. Herodotus, the Greek Historian, tells of Atossa, the wife of the Emperor Darius, who developed an abscess of the breast which she concealed because of shame. It was only after she became dangerously ill that she sought treatment for it. Fortunately, the outcome in this case was successful, but in too many instances such shame about one's body leads to delays which make for irreversibility of the pathological process.

We have been actively engaged in psychiatric evaluation of women with masses in their breast for two years at LSU. During the first year, our study was limited to patients who had been admitted to the hospital for biopsy or for radical surgery. During the second year of study, we moved into the outpatient clinic in an attempt to see the patients on their initial visit with this complaint. It is our impression that with in-patients, the hospital atmosphere rapidly influences the phychological reaction of the patient.

Our interest in the problems of cancer and its psychological aspect was initially motivated by the desire to study individuals who were undergoing severe psychological stress. This disease offered an excellent opportunity for such a study of stress, as it commonly tends to be chronic, frequently irreversible, often painful, and surrounded by many superstitions. In addition to this interest which was purely research, we had become actively engaged in a teaching program in our medical school in which we were responsible for the discussion of the psychological aspects of the cancer problem. This turned our interest from a purely investigative one to the area of practical application in the clinical setting. Finally, we were asked to participate in planning for a symposium on breast cancer to be held in our city, and it was this factor which determined our selection of the breast as the area of initial study. Although the selection of this site was purely accidental, we feel that it is an extremely fortunate choice. The breast is an area of the body, readily accessible to observation, and one about which most women are somewhat knowledgeable. The mass usually develops in a previously asymptomatic area. Because if this, there is relatively little opportunity for the patient to mistake the signs of expanding mass in the breast for those referable to a previous complaint in the same area. This is frequently not the case in lesions of the gastrointestinal tract or of the genitourinary tract.

The material upon which I am going to base this discussion involves only out-patients of our particular study, and information obtained from other workers in this field.

Because this study was done on a relatively small number of patients, we do not feel the material that we have to offer is of statistical significance in the usual sense of the word, but rather the patients must be looked upon as individuals responding in their own unique

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manner, presenting types of response that need to be investigated further. We have detailed information including psychological examination and social service investigation on only twelve patients. These individuals are in various age groups. They come from both the white and negro Southern population. They were all patients at a charity hospital and none of them had college educations.

In the patients that we saw, it was striking that there was a much greater willingness to express concern openly over the possibility of cancer in those individuals who came for care very soon after having discovered a lump in the breast. This fear of cancer in these individuals was always countered by the comment that they knew that if you "got it early," things would work out all right. We doubt seriously that the patients were actually this certain of an optimistic outcome, but at least this is the attitude that they expressed and they did seek early care.

In our group, those individuals who delayed seeking treatment for an unreasonable period of time were individuals in an unsettled family situation. This has been true of both the young patients and the old patients. In our psychiatric evaluation of these patients, it rapidly became apparent to us that all of them were severely depressed. All expressed the feeling of hopelessness and of despondency, and in every instance this feeling of hopelessness was projected into a real family situation. I am not now talking of projection and distortion in a psychotic manner, for the situations were as described by the patient when we investigated them through social service. In the examination we made of these patients, they would occasionally fail to speak about their breasts at all, spending all of their time talking about their other troubles. For example, one of our patients, a woman in her sixties, spent practically all of her time talking about an alcoholic son-in-law who was not supporting the patient's daughter, and who was very hostile to the patient. This daughter was described by the patient as being on the verge of a nervous breakdown from worry, brought on to some extent at least, by the discord between the patient and the daughter's husband. This was the situation to which the patient would return if she were successfully treated for her disability. We can only speculate as to whether or not the patient delayed, consciously or unconsciously, as a method of effecting an escape from this relatively unpleasant situation.

Another patient, perhaps an even more interesting one, a woman in her mid-forties was hospitalized with an inoperable malignant growth nine months after she had accidentally discharged a shotgun through her abdomen. The growth was discovered only by accident when she went to her local physician because of an acute viral infection. This woman had lost her husband when she was quite young, and was left with two small children to raise. She raised the children herself, stating that while her children were young she would not consider marriage, for she would not risk subjecting her children to a stepfather who might be less kind and tolerant to them than she desired. Shortly after the marriage of her son, the daughter being already married, she began actively to socialize, and soon married. Within a year the son had developed an acute schizophrenic reaction, his wife had deserted him and their child, and the son returned to the patient bringing with him the grandchild. The patient stated that she was very upset about this, as she had to do something that she said that she would never do, and she saw no solution to the problem. It is, I think, not unlikely that the accidental shooting was strongly motivated by the desire to escape from an intolerable situation, and I suspect that the neglect or lack of awareness of the lesion in an intelligent and observing woman might have been due to the same reason.

Another finding that was consistent throughout our series was that women past the child bearing age openly expressed more concern about the possibility of loss of breast than did the women who were still in the child bearing age. These elderly women could not give a very clear explanation of why they were so concerned about the loss, whereas, the younger women clearly expressed the regret over such a possibility, but stated that if loss of breast was necessary for them to remain alive, they would willingly give it up.

One finding which was incidental, and I hope not very common, is that a physician, closely associated with a patient, appears to be more likely to deny the possibility that a lesion is malignant, and therefore needs definitive investigation, than is a physician who is able to view the patient more impersonally.

With these generalizations from our own studies, I would like to turn to the more theo-

retical aspect of the problem and discuss some of the psychological phenomena that are present with this type of illness, how these phenomena can be recognized, and how, by this recognition, the physician can be of more service to the patient.

A number of workers have attempted to formulate some principles or rules of behavior that appears to be applicable to stress in general.

In evaluation of an individual's response to stress, three factors must be considered: First, the general reaction to stress. Second, the personal reaction to stress. Third, the nature of the stress.

The general reaction to stress might be considered to be the sequence of responses that are likely to occur in an individual who is subjected to stress of varying degrees of severity of whatever nature. For ease of discussion we might assume that the stress is considered by the patient to be of a catastrophic nature. The general reaction then would be considered to be the course of events from the time of the recognition of the stress to a point where there is a resolution of the stress either by mastery or by destruction. Illness may be looked upon as such a nonspecific stress to which an individual is subjected.

It might be noted that in the particular situation that we are describing, the patient may use these mechanisms at the time of discovery of a mass in the breast, may work through them at various levels, can then repeat the sequence at the time of the physical examination and the discussion of the problem by the physician, and finally again at or after surgery, and during the course of the termination of the illness. Each of these phases of the illness, the discovery by the patient, the examination and explanation by the physician, and the treatment procedure are all stresses and must all be handled by one means or another.

Table I gives a schematic representation of one proposed sequence in such a situation. Phase 1, the state of disorganization comes at the point of recognition of a stress, and may last for varying periods of time. Some individuals subjected to severe stress appear to lose all ability to organize their thoughts and

GENERAL REACTION TO STRESS

Phase One	The Period of Disorganization
	A. Chaotic Reaction
	B. Depersonalization
Phase Two	The Period of Assimilation
	A. Projection
	B. Denial
Phase Three	The Period of Mastery
	A. Grief
	B. Resolution
	1. Childish dependency on Physician
	2. Omnipotent identification
	3. Adult cooperation and acceptance

(Modified from Shands)

behavior, and behave in a chaotic manner. This is seen, for example, in the individual who brings something of a relatively trivial value out of a burning house, or who actually might rush back into a house that is about to collapse for an object of trivial value. A patient, who has been told of a serious illness, may get up and leave the office, and later deny that she was told of her illness by the physician. She was completely unable to assimilate the information into her awareness, and was therefore unable to utilize medical assistance. This is, as a rule, fairly transient. The individual then goes into the phase that has been described as depersonalization where they are aware of what has taken place, but they seem to be at the moment unable to realize that it is happening to them. The patient later describes having gone through a period when she was well aware of what the doctor said but it seemed that the physician had been talking about someone else.

It is obvious, of course, that in either instance, the patient is temporarily overwhelmed by the impact of the information, and is unable to do anything with it and therefore finds difficulty in accepting the need that something must be done.

The next phase, that of assimilation, occurs at the point where the patient is able to recognize the implication of the situation but attempts to handle the anxiety by discrediting the informant. This can be done by projection, in which case, the responsibility for the situation is placed upon outside sources. In the

medical setting, it is commonly seen in the complaint that the illness is the doctor's fault, or the nurse's, or what have you. This, of course, can lead to unpleasant consequences and should always be recognized as one of the complications likely to occur in any serious illness. It is usually handled fairly easily without damage either to the physician or to the patient. Denial, on the other hand, can be much more serious because it can lead the patient to refuse medical care, stating that the information that she has received is inaccurate and that there is actually nothing wrong with her. This is quite different from the lack of awareness exhibited in the stage of disorganization, because in this instance, the patient is actually aware of what is being told her, is aware of the implication of the situation, but by the magic method of saying that it isn't so, is attempting to handle the problem. Phase three, the phase of mastery is initiated by the recognition of the implication of stress, and by the natural grief that it might be associated with any loss or deprivation that is likely to take place. This is followed by a stage of solution where the patient may solve her problem by (1) becoming a relatively helpless dependent individual, (2) by developing an omnipotent identification with the physician, or (3) ideally by accepting a realistic evaluation of the situation, and development of behavior commensurate with the reality.

This brief outline of the general reaction to stress shows how an individual can go through various phases of psychological responsiveness during an illness, or during the period of medical examination. It is clear that there are many modifications of this procedure based upon the individual capability and potential of the patient. The individual, subjected to medical illness, is likely to respond in a pattern consistent with her usual reaction to stress. The discovery of a mass in the breast, or the information that surgery is necessary, or finally, the recognition that surgery was unsuccessful is a stress situation to which the individual can respond only with her general pattern of behavior. This can be illustrated in the next table where a number of type reactions are listed that might be expected to occur in women with breast mass.

SPECIFIC REACTIONS TO STRESS

1. Dependency
2. Anxiety
3. Depression
4. Compulsive Reaction
5. Paranoid Reaction
6. Schizoid Reaction

(After Sutherland)

It is evident from comparison of, or with, Table I that there are some reactions that are common to both. There is a likelihood of a general depressive reaction to the recognition of serious illness, and in addition, certain individuals are likely to behave in a consistently depressed manner with a greater degree of depression that is common in the general population. These responses need little or no amplification, because they are the emotional reactions that are seen in various types of psychiatric patients, or in individuals with mild personality patterns of this type. It is important that they be recognized, however, because the method of handling the individual should be influenced by the general personality pattern. For instance, the anxious individual is likely to require considerably more reassurance than another individual not chronically anxious. The individual with anxiety is also likely to react more readily and rapidly to the development of symptoms, and will seek help earlier, and may therefore have a somewhat better prognosis than will some of the other types. The depressive individual, with a feeling of general hopelessness, or who feels unworthy, might, as a reaction to this attitude, fail to ask for sufficient care, and could then come in to the physician in a terminal state as the result of delay brought on by this depressive attitude. We have already discussed how the paranoid, or projective mechanisms, may cause difficulty in relation

to the general reaction. The schizoid reaction can result in a general denial or failure to handle the situation, and it also has been described to some extent in the general reaction. The compulsive person will follow orders well, and can, in many instances, gain immeasurable help if this is recognized and the patient is offered certain rituals to carry out. The dependent individual we do not need to describe; he is well recognized and will insist himself that you care for him.

We have now talked about the general reaction, and the specific reaction. It is now necessary for us to recognize that in addition to the general personality characteristics, the reaction of an individual is going to be determined, to some extent, by the specific nature of the stress.

Stress of any sort has its specific consequence to the individual. The stress of illness has associated with it the possibility of loss of function, of pain, and loss of body integrity to death. The byproducts of such loss of function might include the loss of independence, the loss of status activity, and the reduction in social desirability.

Recovery from illness is not always an uncomplicated return to the previous state of well-being; not infrequently, recovery is secured at the expense of a loss of body part, with an associated reduction in body function, and reduction in the concept of desirability. This loss varies with the level of awareness of the body part, and with the specific values associated with it.

We know that the breast, by its very nature, has a high emotional charge. The girl, from the time of puberty, well within the limits of conscious memory, is highly motivated to place much emphasis on the breast. The developing breast is the first public evidence of beginning womanhood. No matter whether cherished or bitterly rejected, feeling associated with such an organ is strong. This importance is rapidly reinforced by the tentative explorations and approaches of the adolescent boy friends, making the breast not only a harbinger of womanhood, but an integral part of adult sexuality. Depending upon the overall attitude toward sex at this point and later, this interest might develop as a healthy component of maturity, or might be repressed either with denial or reaction formation associated with conscious and unconscious guilt.

During adulthood, there is further reinforcement of the feelings associated with the breast, whether the woman be single or married, reproductive or barren, and finally after the menopause the breast remains, long after the cessation of the menses, as a reminder and a symbol of femine sexuality.

It is little wonder, with this heritage of psychological sensitization, that a lesion occuring in the breast is likely to cause much more reaction than would a similar disturbance in most other parts of the body.

The emotional reaction to the healthy breast can range from an almost complete denial of its existence, through reaction formation which creates an attitude of disgust and rejection as if it were dirty, through a healthy respect and regard for a decorative and utilitarian part of the anatomy, to a narcissistic preoccupation and over-evaluation.

These specific attitudes toward the breast will influence the general reaction of the patient to discovery of a breast mass. The individual, who devaluates, may either fail to care for herself adequately, or she may, because of her depreciatory attitude, come rapidly to the physician with the expressed joy of being able to get rid of this useless appendage that has been nothing but a bother and a burden anyway. Beware of such acceptance, it usually hides severe depression, frequently associated with suicidal guilt. At the other extreme is the narcissistic individual who demands immediate repair and restoration to previous states of function. The loss of self esteem, secondary to the narcissistic insults to the body, may result in refusal to accept surgery, or in depression and suicide after surgery, if it is not recognized and handled.

We must not fail to recognize that many women do not live in isolation, but have husbands who are important in their lives. The attitudes of the husband toward the wife is important, not only before surgery when it may actually delay surgery as it did in one of our cases, or afterwards when it may ad-

versely influence the postoperative course if not taken into account.

The particular patient, to whom I have reference, came to the hospital with inoperable metastasis. She had discovered a mass months earlier, surgery was recommended but it has been delayed while her husband underwent an elective herniorraphy and prolonged convalescence during which time the patient nursed him. She was justifiably depressed over this.

We must also recognize the role that the physician plays in such situations. He can, by his actions, at times influence the patient to a favorable outcome, at other times an unfavorable one.

I am sorry that I have not been able to present data that would make the reaction of the woman with a breast mass easy to predict and simple to handle. It is beyond my capability to do so. I have attempted to present a few conclusions drawn from a limited number of cases, and then to discuss some general rules of behavior which influence the individual patient. I can only say that it is most important for the physician to recognize that emotions influence the patient's response to illness. These emotions can only be handled effectively if each physician recognizes them, and allows enough time for each patient, so that he can become as conversent with the emotional aspects of the patient's structure as he does with the more easily instrumented aspects of the organism.

It is not possible to achieve pathological cure of each breast mass. It is, however, within the responsibility of each physician to offer the maximum relief from suffering, including psychological. This can be done only if the physician is willing to take on this most important, and, to the physician, the most sobering task of medicine—the care of the patient through a terminal illness.

As physicians we do not prevent death; we can, if we are fortunate, help prolong life. We should assist the patient to approach death with dignity and comfort. They have little at such a time but their self respect. The proper assistance in the psychological area helps preserve this.

Treatment of Venous Ulcers of The Leg, Review of 110 Operative Cases. William H. Prioleau, M. D., and Daniel B. Nunn, M. D. (Charleston). Annals of Surgery 149, 914-924, June, 1959.

In extensive primary varicose veins and in postphlebitic cases the development of venous ulcers is the result of both the underlying venostasis and the local factors of incompetent perforating veins and the dependency of the ankle. Before definite operative measures can be undertaken, the venostasis must be brought under control and there must a regression of the inflammatory changes in the region of the ulcer. This is accomplished by supportive boot therapy, the importance of which cannot be overemphasized. The operative procedures consist of interrupting incompetent communicating veins, particularly in the femoral and popliteal regions, excision of varicosed trunks and plexuses, and ligation of incompetent perforating veins in the leg. Staging the operation is necessary under some conditions. Excision of the ulcer is seldom necessary.

The injection of sclerosing solutions has been abandoned on account of the risk of causing thrombosis in the deep veins. Tourniquet tests and venograms have little practical value in the managements of the case.

Two hundred and seventeen private cases of venous ulcer have been reviewed. Follow-up data on 110 operative cases have been evaluated. In patients treated by limited vein excision in conjunction with the injection of a sclerosing solution, the results were poor and, in some instances, the condition of the patient was made worse. In patients treated by extensive vein excision through horizontal incisions, there was a high incidence of persistence or recurrence of venous ulcer. The results were greatly improved in those cases in which vertical incisions were used in the leg in order to locate more accurately the incompetent perforating veins.

Patients who have had venous ulcer should be examined at intervals for the development of new incompetent perforating veins and varicosities which may lead to recurrence of ulcer formation.

The application of the supportive boot is well portrayed by four illustrations.

THE EMERGENT MANAGEMENT OF THORACIC TRAUMA

WENDELL M. LEVI, JR., M. D.
SUMTER, S. C.

Introduction

Thoracic trauma has become a progressively more important problem in civilian medical practice in the past twenty years. This can be well attributed to the advent of high speed transportation and the use of motorized equipment in all walks of life. A basic understanding of the emergent treatment of chest injuries is an absolute necessity for every practicing physician, as well as the surgeon. Correct and prompt attention to such injuries can be life saving.

During the second World War, the correct management of thoracic wounds received a great impetus. Great refinements were made in the handling of large numbers of acute battle injuries. Basically, no change has been made in this method of therapy. Shefts[4] aptly pointed out that when the experience in the battle zones increased, there were fewer thoracotomies performed. He also warned against panic decisions and stampedes to the operating theater.

Parker[2] in 1947 estimated that injuries to the chest comprised 5 to 8% of the admissions in a busy general hospital. This figure is now probably slightly higher. This paper will try to present briefly, the main types of injuries to the chest and the salient methods of handling.

An understanding of the basic physiology of the thorax is absolutely essential to both treatment and discussion. Normal ventilation and gaseous exchange requires a rhythmic muscular action, a semi-rigid thoracic cage, and an unobstructed airway. The normal intra-pleural pressure on inspiration is —9 to —12 cm. of water and on expiration —3 to —7 cm. Maintenance of this negative intrathoracic pressure with a completely expanded lung in a dry pleural cavity should be our aim in the management of the injured thorax.

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Discussion

The patient with the injured thorax is most often seen in one of our busy accident wards. Here the most important phase of therapy is accomplished. Immediate evaluation and examination is carried out. The patient is undressed completely. Chest injuries are commonly associated with multiple systemic injuries and a thorough evaluation is essential. One should note especially the color of the lips, and nail beds, the pulse, blood pressure, and respiration. In addition to routine percussion and auscultation, observe for splinting as well as the depth and rate of respirations. Also, note any parodoxical chest motion. Palpate the chest for subcutaneous emphysema, fractured ribs, tenderness, and induration. This can be accomplished in several minutes while a large bore needle or polyethylene catheter is being inserted intravenously. Blood is drawn for typing, matching and cross matching. Shock is practically always an accompaniment of thoracic injuries both from disturbed physiology and blood loss.

One must realize that until the basically disturbed pulmonary pathological changes, such as tension pneumothorax or mediastinal flutter, are corrected there will be no change in the status of the patient despite blood volume replacement and vasopressors. One should remember that narcotics which depress respiration and decrease the cough reflex should be used sparingly. Constant physician attendance during this phase of therapy is mandatory.

Any "sucking" wound should be covered immediately with an occlusive dressing. Smaller wounds may be debrided and closed under local anesthesia. It is important when the patient is to be transported to another location, that the wound not be sutured. Thus, if there is a continued air leak and resultant tension pneumothorax, there will be a route of escape. In the larger wound or traumatic thoracotomy, we see the phenomena

of mediastinal flutter. The collapsed lung falls away from the chest wall on inspiration and moves towards the chest wall on expiration. While the collapsed non-functioning lung increases the normal dead space of the tracheobronchial tree, the normal intra-pleural pressure of the contra-lateral lung is also disturbed. In addition, the inadequate filling of the right side of the heart markedly reduces the stroke volume. The patient is unable to evacuate his tracheo-bronchial secretions and marked respiratory distress can ensue. Operative closure of the traumatic thoracotomy should be accomplished with dispatch under general endotracheal or positive pressure face mask anesthesia.

Hemopneumothorax is treated immediately after its diagnosis. Aspiration of as much blood and air as possible, as soon as possible, and as often as is necessary is axiomatic.[5] X-ray examination of the chest should be obtained preliminarily, if the patient's condition allows. A large bore intravenous needle or catheter should be in place and the patient should have constant medical attendance if transported to the x-ray Department. At least posterior-anterior and lateral and preferably both oblique views of the chest should be obtained, with the patient in the upright or semi-upright position. Serial films can be extremely important in chest injuries. After the diagnosis of pneumothorax, the patient is placed in the semi-upright position. A #18 gauge, short bevel, needle connected to a three way stop cock and a 50 ml. syringe is inserted in the second intercostal space anteriorly, in the mid-clavicular line, with local anesthesia. The air is evacuated until a slightly negative pressure is encountered. In the presence of unlimited air aspiration, an intercostal catheter should be inserted anteriorly in the second intercostal space and connected to an underwater trap bottle. If 1200 ml. or more of air are removed and a negative pressure obtained, it is preferable to insert an intercostal catheter because recurrent pneumothorax and unattended tension pneumothorax are likely. In the presence of constant medical attendance, patients who have had aspiration of as much as 2000 ml. of air with a negative pressure being obtained, can be observed closely and thoracentesis can be repeated in an hour. Progressive subcutaneous emphysema after thoracentesis and removal of air is best treated by the use of an intercostal catheter. Caution is necessary in the presence of subcutaneous emphysema and no demonstrable pneumothorax because the pleural space may be obliterated by adhesions and trocar thoracotomy is dangerous. Bilateral intercostal catheters are best inserted in the presence of bilateral hemo- or pneumothorax because sudden unattended respiratory embarrassment can occur.

The costophrenic space lies at the inferior angle of the scapula. Aspiration should be performed here with the removal of as much blood as possible. A #15 to #17 gauge short bevel needle is used for aspiration. Thoracentesis in the mid or posterior portion of the axillary line in the 7th through the 9th intercostal space can be performed with the patient in the semi-recumbent position. If large quantities of blood are removed and replacement is not immediately available, then autotransfusions, as first described by Sanger[3] in 1948 using transfusion vacuum bottles, can be lifesaving.

Tension pneumothorax results from a continued leakage of air into the pleural space without route of egress and resultant positive intra-pleural pressure on the side of the injury. As this pressure increases, a mediastinal shift occurs, and a resultant abnormal intra-pleural pressure on the opposite side. If the condition is not recognized and relieved promptly, death due to asphyxiation can occur. Trocar thoracotomy with the insertion of an intercostal catheter should be carried out promptly. If no equipment is available and the patient is in acute respiratory distress, the insertion of a needle or knife into the intercostal space with the release of the trapped air can be lifesaving. A convenient method when a thoracentesis set is not available is to connect the needle to an intravenous set and to immerse the distal portion of the intravenous tubing in a pan of water until a suitable apparatus can be obtained.

The patient with an injured thorax should be placed in the semi-upright or upright position unless hypotension is present. It is well to remember that the presence of subcutaneous

emphysema in chest injuries indicates that there has been a tear of the parietal and visceral pleura with egress of air into the subcutaneous tissue. Although the visceral pleural tear is usually rapidly sealed off, the patient with subcutaneous emphysema should be observed closely for progression of subcutaneous emphysema, pneumothorax, or tension pneumothorax.

Further, the establishment and maintenance of a dry, open airway is of primary importance. Alleviation of pain locally by intercostal nerve block at least two to three ribs above and below the site of injury is extremely important. Adequate coughing, endotracheal catheterizations, and bronchoscopy are used when necessary. Tracheotomy, although not without complications, is of prime importance in chest injuries. It decreases the "dead space", allows easy removal of tracheo-bronchial secretions, and aids in maintaining an unobstructed airway. It should be performed in cases if paradoxical motion of the chest, in semi-comatose patients with concomitant chest injuries, and in any patient in whom adequate tracheal care cannot be obtained with the endotracheal catheter.

Indications For Operative Intervention in Trauma to the Chest.

1) A thoraco-abdominal wound or its possibility.
2) A large foreign body in the pleural cavity or in the lung.
3) A large chest wall defect or traumatic thoracotomy.
4) Continued intra-thoracic bleeding.

Other indications which are not absolute are 1) tears in the trachea or major bronchi, 2) suspected esophageal injuries, and 3) suspected penetration of cardiac chambers.

Wounds of the thorax may be generally divided into three types. 1) Closed thoracic trauma, and wounds of the thoracic wall. 2) Combined thoraco-abdominal wounds. 3) Penetrating and perforating wounds of the chest.

Closed Thoracic Trauma: These injuries are due generally to blunt trauma. The most common injury is a fractured rib. Treatment consists of alleviation of the pain and establishing an effective cough. Strapping is considered less effective than nerve block. Narcotics which diminish the cough reflex should be used sparingly. Simple intercostal nerve block which may be repeated every eight to twelve hours gives satisfactory results. Open reduction may occasionally be necessary for relief of pain.

One of the common complications of this type of injury is the "wet lung", or traumatic pneumonitis. DeTakats[1] *et al* considered this due to reflex motor and secretory stimulation of the bronchial tree which produced bronchospasm and excessive bronchial secretions. It is characterized by a wet, ineffective cough, coarse rales, wheezes, and fever. Treatment consists of obtaining an effective cough and tracheo-bronchial aspiration.

The "flail" or "crushed chest" is a common injury with today's high speed transportation. Immediate partial alleviation of the paradoxical respirations may be accomplished with sandbags. Prolonged fixation of the flail portion of the ribs or sternum may be done in numerous fashions. Cervical tenaculums, towel clips, screw eyes, etc. may be inserted into the sternum or ribs and about 5 lb. traction applied. This method demands complete immobilization of the patient and should be avoided. A method of fixation which allows mobilization of the patient and also movement of the sternum with the ribs is highly desirable, and has been described by Shefts.[4]

Traumatic rupture of the diaphragm, though rare, usually occurs from compressive injuries of the abdomen or costal margins. The left side of the diaphragm is more frequently involved than the right because the larger right lobe of the liver protects the right diaphragm. Difficulty in diagnosis is frequent, because of the overlying hemothorax and the differentiation between a high-lying stomach and a herniated stomach through a lacerated diaphragm. Immediate surgery is not demanded in right diaphragmatic rupture unless the lacerated liver continues to bleed, but suture of the laceration with subcostal drainage should be carried out as soon as the patient is in the optimum condition. This is mandatory in the prevention of bile empyema or pleuro-biliary fistula. Emergent thoracotomy is important with rupture of the left dia-

phragm because of the high incidence of secondary intestinal obstruction, or splenic injury.

Costo-chondral and costo-sternal separations require no immediate treatment other than the relief of pain. Operation may be desirable later for cosmetic reasons.

Tears of the trachea or bronchi result from shearing or crushing injuries of great force. The presenting clinical picture is one of massive pneumothorax or tension pneumothorax, massive subcutaneous emphysema, and mediastinal emphysema. Characteristically with mediastinal emphysema there is shock in the presence of marked respiratory embarrassment, severe substernal pain, and respiratory crunch. The treatment of the associated pneumothorax usually relieves the condition. Tracheotomy and anterior mediastinotomy may be necessary for relief of the mediastinal air. Although the immediate treatment of the tension pneumothorax may alleviate the condition, the persistence of massive pneumothorax despite catheter drainage indicates a large tracheal or bronchial tear. Urgent operative intervention is recommended for repair of the defect and prevention of later complications of either stenosis or atelectasis or both.

Thoraco-abdominal Wounds: These are wounds which involve the pleural cavity, diaphragm, and abdominal peritoneal cavity. A diagnosis or suspicion of penetration of the diaphragm is an indication for surgical intervention. One must always consider the range of motion of the diaphragm and the depth of the costophrenic sulci. Air beneath the diaphragm when present is, of course, indicative of injury to a hollow viscus and it is notable that this finding is present less frequently than suspected. Closure of the diaphragmatic perforation and visceral wound are accomplished and subcostal drainage instituted in the presence of liver fracture. Transthoracic, transdiaphragmatic exploration is the procedure of choice in wounds confined to the upper part of the abdomen. Separate laparotomy and thoracotomy incisions are considered preferable to thoraco-abdominal incisions in wounds involving the lower abdomen.

Penetrating and Perforating Thoracic Wounds: Although these wounds are more common in warfare, the large Southern community is frequently a fertile ground for these injuries. The agents of wounding are usually knives, icepicks,pistols , and rifles. The colored male is most often involved, and these injuries appear to be more frequent in summer. It is extremely important to obtain information as to the type weapon used and its manner of use. Icepicks which are commonly wielded by women are delivered usually with an overhand thrust. A wound made by an icepick or thin knife blade can often be hard to find, and careful examination of the skin of the chest is essential.

Although from reported experience gained in combat injuries, we know that a bizarre course of missiles is rare, one can never predict with absolute accuracy the path of a bullet. Most often if one lines up the wounds of entrance and exit, the involved organs can be fairly accurately outlined. The greatest amount of damage can be done by secondary missiles such as bone, and by missiles of the highest velocity.

In the case of the large chest wall wound or traumatic thoracotomy, there is no question of indication for thoracotomy. The thoracotomy wound must be debrided and closed.

Shock present in a patient with a penetrating or perforating wound of the chest is usually secondary to blood loss. The mere presence of a hemothorax, regardless of the amount of blood present, is not of itself an indication for thoracotomy. There are three main sources of bleeding in the thorax.

1) Lungs. The branches of the pulmonary vessels in the pulmonary parenchyma.

2) Thoracic wall. The intercostal, subclavian, and internal mammary arteries.

3) Mediastinum. The heart, great vessels and their immediate branches.

Bleeding from the lung parenchyma and smaller branches of the pulmonary vessels is seldom a problem because of the low pressure in these vessels. Also hematoma, and "splenization" of the lung can produce tamponade of the site of laceration. Intercostal vessels can frequently be a source of continued bleeding. The problem of trauma to the heart and adajacent great vessels will not be covered by this discussion.

A suspicion of an esophageal injury requires exploration in most instances. An absolute diagnosis of perforation or rupture of the esophagus can be made only by use of a radio-opaque material, and its appearance outside the esophageal lumen in the mediastinum or in the pleural cavity. Thoracotomy with repair of the injured segment and adequate drainage should be carried out.

Thoracotomy is indicated in the presence of a large intrathoracic foreign body. The position of the foreign body is more important than the size. The hilus of the lung or mediastinum is the most dangerous area. Smaller foreign bodies in the hilar region may be removed electively or when the patient is in the optimum condition. All intrapleural foreign bodies, even though asymptomatic, are preferably removed electively.

Perforation of the trachea and major bronchi as in rupture secondary to blunt trauma is associated usually with marked subcutaneous emphysema and mediastinal emphysema. In most instances of injury to the trachea or bronchi the resultant mediastinal emphysema rapidly dissects the neck, face, and moves retroperitoneally with swelling of the flanks, scrotum, and lower extremities. Pneumothorax is almost always associated with lacerations of the major bronchi. In the presence of pneumothorax, widened mediastinum, mediastinal crunch, and subcutaneous emphysema, laceration of the trachea or bronchus should be suspected. Tracheotomy is especially applicable in these cases. Operative intervention in cases not controlled by catheter thoracotomy is the same as outlined in rupture secondary to blunt trauma.

By way of summary, a brief presentation has been given in an effort to outline a satisfactory course of therapy in the patient with the injured thorax.

Acknowledgement

I wish gratefully to acknowledge the suggestions and advice of Dr. Edward F. Parker in the preparation of this manuscript.

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Factors to be considered in the treatment of ovarian agenesis. J. R. Sosnowski, (Charleston) Am. J. Obst. & Gynec. 78:729 (Oct. 1959)

Considering the physiology of secondary sex development and increase in stature, the following program of treatment of ovarian agenesis is suggested:

1. In order to individualize treatment, chromosomal sex, roentgenographic bone age, and thyroid function should be determined in addition to estrogen and gonadotrophin assays.
2. Cyclic estrogen therapy in sufficient dosage to produce secondary sex development.
3. Progesterone therapy if necessary to control estrogen withdrawal bleeding and/or to enhance breast development.
4. Thyroid therapy only if there is clinical and laboratory evidence of deficiency.
5. If a patient having reached pubertal age has demonstrated no increase in stature for the past 6 months, androgen therapy should be instituted immediately, provided the epiphyses are still open. If the patient is demonstrating increase in growth, androgen therapy should be withheld until the patient is within approximately 2 years of the average time of arrest of skeletal growth.

URETEROILEOSTOMY FOR URINARY DIVERSION[1]

R. RANDOLPH BRADHAM,[2] KENNETH M. LYNCH, JR.[3] AND
E. J. DENNIS, III[4]
CHARLESTON, S. C.

Segmental ureteroileostomy (Figure 1) was popularized by Bricker[1] in 1950 for patients having urinary bladder resections as part of pelvic evisceration. Since that time this procedure has also been found to be extremely useful for urinary diversion associated with other conditions. It is relatively free of most of the complications which follow other means of diverting urinary flow.

The procedure itself is not technically difficult. The urine does not come in contact with the fecal stream. Back pressure or reflux is reduced to a minimum by the wide open external stoma. Peristalsis in the isolated ileal segment prevents stagnation of urine. The technique of mucosa-to-mucosa anastomoses between ureters and ileum greatly minimizes ureteral obstruction. Absorption from the ileal segment is clinically insignificant. Therefore, the favorable aspects of the procedure are: (1) the improved results as determined by pyelography, (2) the low incidence of postoperative urinary tract infection, and (3) the absence of hyperchloremia and acidosis.[2]

The purpose of this paper is to demonstrate by case reports the conditions which can be improved by this type of urinary diversion.

Indications for Ureteroileostomy

Pyrah[3] cited the following as indications for ureteroileostomy:

1. Spina bifida with urinary incontinence. (Not to be considered before age ten to twelve years).
2. Certain cases of paraplegia.
3. In pelvic exenteration to avoid a wet colostomy.
4. Vesico-vaginal fistula.

In addition to these we believe that bilateral ureteral obstruction with progressive renal damage can be an indication for this operation.

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2. Assistant Professor of Surgery.
3. Professor of Urology.
4. Assistant Professor of Obstetrics and Gynecology.

Case 1.

M. G., MCH #5940, an eleven year old girl, had repair of a myelomeningocoele in infancy. She had urinary incontinence from birth associated with numerous episodes of urinary tract infection for which she was almost constantly receiving antibiotic therapy. There was roentgenographic evidence of reflux of urine in the left ureter and of hydronephrosis. The kidney function was good. The urinary bladder was chronically infected, thickened, and trabeculated by hypertrophy. The urine culture was positive for coliform organisms. She was constantly wet and required fifteen to twenty diaper changes a day. It became impossible for her to carry on normal school work or to engage in any social activities. Ureteroileostomy and incidental appendectomy were carried out on August 5, 1958. Her postoperative course was satisfactory and there have been no episodes of urinary tract infection since operation. She recently graduated from grammar school and is engaging in normal social activities.

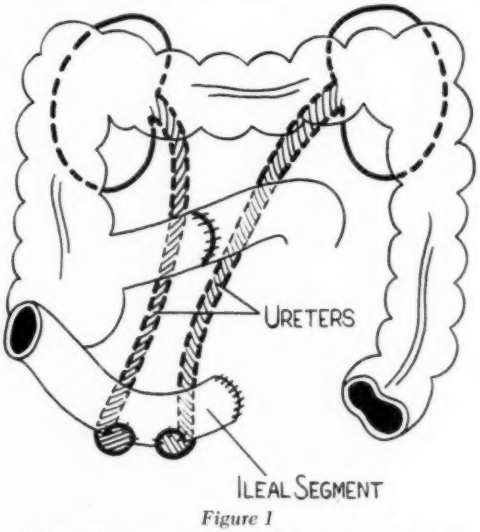

Figure 1

The ureters are anastomosed to a segment of terminal ileum. The distal end of the isolated ileal segment is brought out through the anterior abdominal wall.

Comment: Ureteroileostomy for this type of case has been described by others[4] as providing a socially acceptable, safe, and convenient means of urinary control. Ulm[5] suggests that these disabled disconnected bladders need not remain forever useless and cites

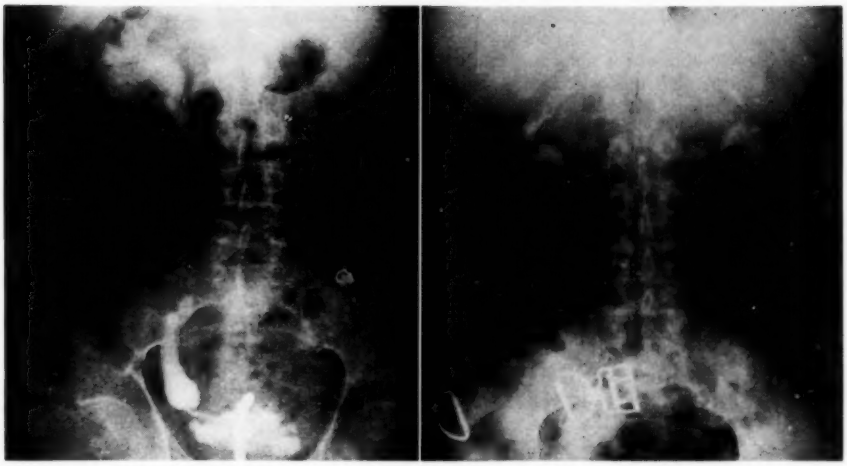

Figure 2.

Case 3. (A) Pre-operative retrograde pyelogram demonstrating hydroureter and hydronephrosis on the right. The left ureter would not accept a catheter.

Case 3. (B) Intravenous pyelogram six months following ureteroileostomy demonstrating normal kidneys and ureters.

a case that was rehabilitated so well by bladder rest that the ileum was anastomosed to the bladder after eighteen months. Urethral sphincter control is regained before this can be done, however.

Case 2.

M. B., MCH #20398, a 37 year old female, sustained a back injury four years prior to admission which resulted in paraplegia. She was incontinent of urine and her neurogenic bladder had a capacity of only 60 milliliters. Because she was constantly wet, rehabilitation on braces was extremely difficult. Ureteroileostomy was performed on January 22, 1959. The postoperative course was satisfactory and ambulation on braces progressed rapidly.

Case 3.

W. B., MCH #11408, a 50 year old white male paraplegic of five years duration with a neurogenic bladder, had been virtually bed ridden and had acute and chronic pyelonephritis. Cystograms, cystometrogram, and cystoscopy with retrograde pyelography were done. These revealed a bladder capacity of 200 ml. and bilateral hydronephrosis and hydroureter. The level of the ureteral constriction was at the ureterovesical junction. Ureteroileostomy was performed on February 3, 1958. Other than urinary tract infection immediately postoperative, this patient has been free of pyelonephritis since discharge from the hospital. Intravenous pyelograms done six months later revealed normal kidneys and ureters. (Figure 2).

Comment: Cases 2 and 3 were paraplegics who could not be rehabilitated on braces because of continuous wetting. The ordinary types of urinary drainage by catheter and condom drainage were ineffective. Case 3 was in incipient renal failure because of progressing renal damage. Both were improved remarkably by the ureteroileostomy.

Case 4.

I. C., a 57 year old female, was treated one year prior to admission with intra-cervical radium for carcinoma of the cervix, stage III. She was incontinent of urine for almost a year. Repeated biopsies of indurated adnexal tissue were negative. Intravenous pyelograms were negative. A vesico-vaginal fistula was clearly demonstrated on physical examination and by cystoscopy. There was fixation of the pelvic organs and marked edema of the urinary bladder and rectum. Repair of the fistula was not feasible. Ureteroileostomy was performed on July 16, 1958. The postoperative course was satisfactory and the patient has been much more comfortable since operation with this type of controlled collection of urine.

Case 5.

J. P., MCH #15852, a 45 year old male, had electroresection of a carcinoma of the urinary bladder in November, 1956, in another hospital. This was followed by a 30 day course of low voltage roentgen therapy. Because of almost exsanguinating hematuria and dysuria, he was referred to the Medical College Hospital. Cystoscopic examination in June, 1958, revealed a large sessile tumor just within the vesical neck which was examined by biopsy and found to be transitional cell carcinoma of a moderate grade of

malignancy. Intravenous pyelograms revealed hydronephrosis bilaterally. On July 2, 1958, laparotomy was performed. The bladder tumor was not resectable so a ureteroileostomy was done because of obstruction of the ureters and hemorrhage from the tumor. Following the operation, the patient got along well for a few months but subsequently developed severe pelvic pain. The neoplasm progressed rapidly and death occurred one year following operation.

Comment: At the time of operation, there was rapidly developing ureteral obstruction due to neoplastic involvement of the trigone. It was our belief that had not ureteroileostomy been performed, he would have succumbed much sooner from obstructive uropathy and uremia or from hemorrhage.

Case 6.

E. H., a 51 year old female, had a supravaginal hysterectomy in September, 1958, in another hospital. The operative specimen contained epidermoid carcinoma. She was admitted to the Medical College Hospital in November, 1958. Because conditions in the pelvis were favorable, the decision was made to do a pelvic evisceration and ureteroileostomy. This was carried out on November 12, 1958. Carcinoma involved the left ureter at the uretero-vesical junction necessitating high division of this ureter. She developed a wound infection and leak of one of the uretero-ileal anastomoses. These complications resolved and since discharge she has gotten along well.

Case 7.

M. W., a 50 year old female was admitted to the Medical College Hospital in April, 1956. She had been treated elsewhere for carcinoma of the cervix, stage I. Biopsies of the cervix revealed recurrent epidermoid carcinoma. Intravenous pyelography demonstrated bilateral hydroureters and hydronephrosis. She was having severe pelvic pain controlled only by large doses of narcotics. On May 25, 1956, pelvic exenteration with urinary diversion by ureteroileostomy was performed. The postoperative course was satisfactory. Narcotics were no longer necessary for relief of pain. Intravenous pyelography one year later showed normal kidneys and ureters.

Comment: Both cases 6 and 7 demonstrate the original application of ureteroileostomy. It has been found to be a far more satisfactory means of urinary diversion than the wet colostomy formed by implantation of the ureters into the segment of descending colon brought out through the abdominal wall. The complication encountered in Case 6 was believed to be due to tension on the left uretero-ileal anastomosis caused by a short proximal ureteral segment and edema of the ureter at the level it was divided. Drainage was effectively established through the perineum until the fistula closed. Case 7 obviously exemplifies the maximum benefit that can be obtained from pelvic exenteration. There is no evidence of recurrent neoplasm in this patient. It is important that she has had no difficulty with recurrent urinary tract infection. This has unquestionably been the major complication as well as the cause of death in many of the patients undergoing pelvic exenteration who had urinary diversion by some other method.

Discussion

Segmental ureteroileostomy has been widely accepted as a means of satisfactorily diverting urinary flow to the exterior. It is safe, socially acceptable, and convenient. The patient keeps a collecting receptacle over the ileostomy opening at all times. The Rutzen bag, the Lapides device, and the Con-Seal enterostomy appliance are all satisfactory devices for collection of the urine. These receptacles can be emptied at anytime without removal. Re-application is usually necessary every two or three days.

The segment of ileum serves as a renal protective mechanism since the active peristalsis prevents stasis and minimizes re-absorption of the urine. Eismen and Bricker[6] showed by infusion of ileal segments that both chloride and urea are absorbed appreciably but clinically they did not find this absorption to be a problem.

Stamey and Scott[7] found no evidence of diuresis from urea absorption or chronic potassium loss in 14 patients. The short length of the ileal segment, the rapid evacuation of urine by peristaltic action, and the low concentrations in the urine prevent excessive electrolyte absorption and symptoms of toxicity. Although a short ileal segment is advocated by most authors, Bill *et al*[4] used segments measuring 35 and 22.5 centimeters in two patients without evidence of electrolyte abnormalities six months after operation.

Klinge and Bricker[8] found that the average amount of the segment fluid volume emptied at one time in the supine position is highly constant between 56 and 63 per cent of the total volume. In the cases presented we have observed no evidence of toxicity from reabsorption. In several who were re-admitted for unrelated reasons, electrolyte determina-

tion were found to be within the normal range.

Technique

Our technique has been essentially that described by Bricker.[9] All patients are placed on sulfathaladine for five days and neomycin for one day pre-operatively. A left paramedian incision is made beginning just above the umbilicus and extending inferiorly to the symphysis pubis.

A segment of terminal ileum with a good blood supply measuring 8 to 10 inches in length is selected. Before this segment is isolated, the right and left ureters are identified and divided several centimeters beyond the level of the iliac arteries. The left ureter is brought under the sigmoid mesocolon through a tunnel in such a way as to avoid angulation. Mobilization of the ureters for distances more than six centimeters proximally is avoided so as to prevent impairment of their blood supply. The selected segment of ileum is isolated by transection of the intestine at the proximal and distal ends. The distal end of this segment is usually located approximately five inches from the cecum. The incisions in the mesentery must be short and the base of the mesentery to the ileal segment should be kept as wide as possible. Continuity of the ileum is re-established by a two layer end-to-end anastomosis. The defect in the mesentery is closed. The proximal end of the ileal segment is closed with a double row of inverting sutures. (Figure 3)

The most important part of the procedure is proper end-to-side, mucosa-to-mucosa anastomoses between the ureters and the ileum (Figure 4). Both ureters are sutured to the adventitia of the ileum with 4-0 silk sutures. Openings of the size of the ureters are then made in the ileal wall, usually on the antimesenteric border. An internal row of interrupted 4-0 chromic catgut sutures are then placed through the full thickness of ureter and intestinal wall. As many of them as possible should have the knot tied on the interior of the anastomoses. The anterior layer of fine silk sutures are placed in such a way that as little ureter as possible is turned in.

The external stoma is created by excising a circular piece of the entire thickness of the anterior abdominal wall at a point midway between the umbilicus and the anterior superior spine of the ileum. The distal end of the isolated segment is brought through this, everted, and sutured to the skin. The right lumbar gutter is not closed. The tunnel created between the mesentery of the isolated segment and the left ureter must be closed to prevent herniation of bowel through this defect. A bag

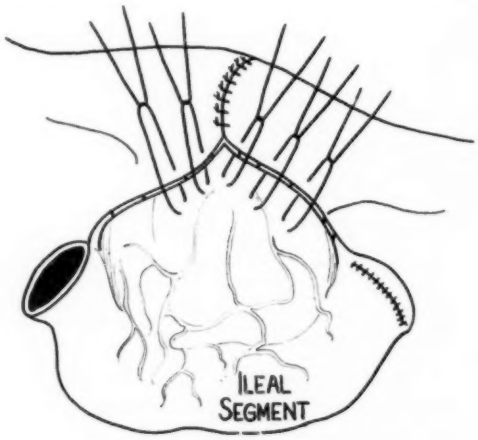

Figure 3.

Continuity of ileum is re-established by two-layer end-to-end anastomosis. The mesenteric defect is closed. The proximal end of the isolated ileal segment is closed with inverting sutures.

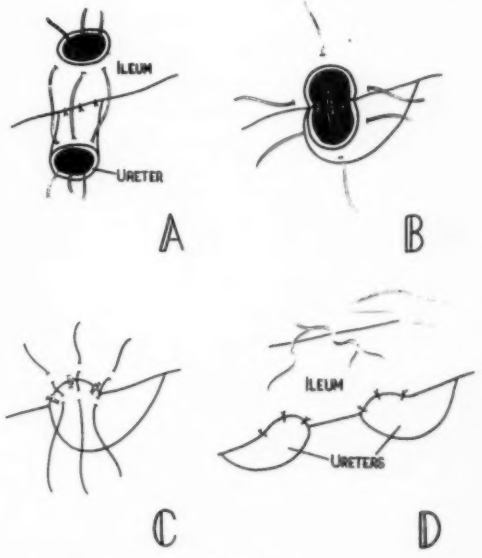

Figure 4.

End-to-side mucosa-to-mucosa anastomoses between ureters and ileal segment.

may be applied over the stoma to the skin when the operation is completed.

Summary

The indications for ureteroileostomy for urinary diversion include spina bifida with urinary incontinence, certain cases of paraplegia, in pelvic evisceration, vesico-vaginal fistulas which cannot be repaired, and in certain cases of bilateral ureteral obstruction. Seven cases have been presented to demonstrate the application of this procedure. The procedure itself is not difficult technically. The incidence of postoperative urinary tract infection is low. Hyperchloremia and acidosis have not been a problem clinically. Renal function is protected by the peristaltic action of the ileal segment, the lack of reflux, and the absence of contact with the fecal stream. The technique has been described briefly.

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MUSIC THERAPY IN THE PSYCHIATRIC TREATMENT PROGRAM

ANN WHITWORTH HOWE*

In surveying the professional field of music therapy, attention should be called to The National Association for Music Therapy. This is an organization of doctors, educators, musicians working in rehabilitation activities, students preparing for the profession, and persons interested in supporting its work.

Music volunteers are used extensively in all kinds of hospitals. In hospitals for the tuberculous, and crippled, and in short term general hospitals, their work is mostly confined toward entertainment, in long term and custodial institutions, this activity is expanded to teaching, coaching music groups and arranging auditorium shows. Volunteers are usually screened and indoctrinated under supervision. They are often sponsored by service organizations, notably patriotic groups, the American Red Cross, or the National Federation of Musicians. Much of this work is of professional caliber. Where funds and personnel are limited, volunteers are often depended on for the hospital's entire program, under medical guidance. Substantial donations of instruments and training scholarships have been made possible by national music fraternities and civic organizations.

The term music therapy has been defined by The National Association for Music Therapy as: "The use of music as an adjuvant therapeutic tool available to the doctor who prescribes the total plan for helping the patient to better health." It is one that has both breadth and depth of emotional appeal, and one which can be subtly used to influence attitudes and moods at a non-verbal level. While the greater use of institutional music is found in mental institutions, this thinking applies not only to this area of mental illness but to the fields of physical handicap and illness as well. Tedium, discouragement, and feelings of exclusion are the usual by-products of all illness, and the door to the alleviating satisfactions found in self-expression as wide for one kind of patient as for another.

All peoples have cherished music because of its unique necessity to man's emotional and social well-being. It has offered appropriate emotional commentary on those chief circumstances of his life which most distinguish him as a human being. From the lullaby to the dirge, music has spoken for him, and to him, when words could not. Music comforted him, has inspired him. It has enhanced his religion, enriched his relationships, and clothed reality with "delightful illusions" so that he might feel freedom and experience pleasure.

By far the greater part of music has some psychological or sociological aim in view other than the purely aesthetic. Music whose primary purpose is other than the aesthetic is called functional music. One phase of functional music is music therapy, the utilization of music in the rehabilitation of the sick. Music readily lends itself to therapeutic purposes. Its usefulness in therapeutic procedure rests upon several principles, among which are the following:

1. Because of its subjectiveness, music becomes the most intimate of the arts, yet it is most adaptable of the arts because it functions in a multitude of ways for nearly everyone. For these reasons music has wide application even in clinical usage.

2. Music dissipates "aloneness", at least for the time of the activity, by re-establishing emotional ties.

3. It is sound without inherent threat, rather than an object that is responded to in music, therefore music becomes a part of reality to be enjoyed and trusted without fear.

4. Form and contents are one in music. Feeling of form is a feeling of relationship. This in turn, then may bring about a feeling of security.

5. Music participation, either listening or performing, provides an easily accepted segment of reality, and thus a platform of reality whereon both patient and therapist may stand

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without disagreement and in confidence.

6. The performance of music generally induces in the performer a beneficial sense of accomplishment and gratification.

7. Music, because of its power to move man deeply, affords an aesthetic control of behavior. Judicious application of music may thus enable a patient to behave on a higher plane.

8. Music is a truth as its universality testifies; by consensus it also has beauty. In music therefore is found a fusion of truth and beauty at a non-verbal level. This value may be adopted by the individual as his own.

9. Music is basically a means of communication and often succeeds where less subtle means fail.

10. Music allows patients a cooperative activity without conflict, therefore making for resocialization.

11. Music is only a part, although an important part, of the therapeutic milieu.

12. Music offers for the patient a Gestalt or sensory-motor-emotional and social components.

13. Moods elicited by music derive from the tender emotions. Music may, therefore, effectively arouse that which is often at low ebb in patients, i.e., the various manifestations of love. This makes possible the transfer of positive feelings for music, to the therapist.

14. Despite the intrinsic importance of music, in a clinical context it is a means toward the more important aim of establishing therapeutic relationship between patient and therapist.

15. The introduction of selected music creates a warm and pleasant atmosphere which helps to induce positive attitudes on the part of the patient toward the hospital environment. This function of music holds true for the medical personnel as well as the patients. Music thus makes an important contribution to morale and patient care.

I have mentioned some of the principles of music therapy and now would like to set forth how music therapy functions in the psychiatric hospital. Throughout the entire country there has been an increasing interest on the part of all thinking citizens regarding the care of the mentally ill and the improvement of their state hospitals. Increasing interest in the therapeutic atmosphere of the hospital has come about through a change from interest in symptoms to interest in the patient's total personality. Recognition that emotional and mental illness may involve every area of the patient's life situation has led to the collaborative activity of the clinical teams, utilizing medical resources towards the patient's personal, social and vocational rehabilitation. The patient's return to the integrated community living, which in the broadest sense is the goal of psychiatric treatment, is facilitated by the collaborative process. There has been a desire to utilize every reputable method of treatment at the South Carolina State Hospital and we are happy that music therapy is now available.

In many outstanding psychiatric hospitals where nurses, attendants and special therapists are expected to carry out a major portion of the treatment and where therapy (rather than mere custody) is the regular practice, it is essential that all persons who come in contact with the patient should maintain a uniform attitude insofar as possible. The physician communicates specific instructions as to medications and activities and designates attitudes to be assumed toward the patient by all members of the hospital personnel.

From the tentative diagnosis and outstanding symptoms, the nurses and therapists gain knowledge of the patient's behavior, attitude and symptomatology which help them in their care of the sick patient. The personal information given is of value in planning occupational, recreational, educational, and music therapy programs by which these adjunctive therapies are able to contribute to the formation and maintenance of a consistant and uniform plan of therapeutic management for the patient.

To outline an effective and broad therapy program, knowledge of normal and abnormal behavior patterns is needed, so that the therapist can talk the language of the doctor who in the hierarchy of the hospital is the guide. Sound specialized knowledge in the music area itself is of course essential for the music therapist to interpret his medium adequately to the physician, for the best machine on a shelf, or working at half capacity, is of little

value. This combination of control of the medium plus proper background in psychology and therapy principles should insure maximum productiveness in laying proper ground work.

The personality of the therapist plays a vital role in hospital work so that he should be both mature and emotionally stable. As for personal qualifications for a music therapist, the National Association for Music Therapy offers as follows: "Good physical health and stamina are essential. Emotional stability is extremely important and no emotional maladjusted person should consider or be advised to enter this field. The music therapist must possess patience, tact, and a genuine desire to help others. The ability to work with others cannot be over-stressed. The successful therapist is frequently one who has faced the problem of choosing between a musical career, teaching, or a career as a nurse or doctor. In music therapy one is able to combine these ambitions in one profession."

In general, the music therapy program at The South Carolina State Hospital falls into five classifications:

1. Workshop activities, which are individual, small ensemble groups, and study groups.
2. Large group activities, which include coached participation, rhythm bands, passive listening and active listening.
3. Music entertainment other than in the auditorium and music rooms.
4. Ward programs—with patient participation, music supplied on request for special affairs anywhere in the hospital.
5. Background music with treatment and music during patient's meals. Combos for dances, or dance orchestra for weekly dances. Patient recitals, community sings, and classes in music appreciation and theory, weekly.

The success of the job demands that certain basic adequacies be allowed: adequate space to provide physical comforts with room enough to work and some degree of attractiveness in the surroundings, adequate tools, by purchase or donation, with privilege of proper care and repair, adequate personnel to implement, helpers on mechanics of supervision and escorts who are agreeable. Too little help in a broad scope program means curtailment or exhaustion of the workers; too much leads to confusion of effort.

Each institution needs its own suitable music programming, fitting to the overall plan of doctor and administrator. These possibilities must be explored by the music therapist, with imagination and flexibility. From the man playing a kazoo in a back ward rhythm band to the lead fiddle in the dance orchestera, from soothing "homespun" bedside program to the well performed anthem of the robed choir at Sunday service there is a broad gamut of possibilities for making the institutional music program vital.

In music therapy lies one answer also to many of the problems of institutional living. Most institutions are of necessity large—music is a leavener which often brings a feeling of freedom and release. Discouragement and lethargy are ever present deterrents to proper attitudes; the arts and the cultural activities offer fine avenues of approach for defeating these enemies of healthy emotional tone.

The cultivation of music appreciation and talents will fortify those who go back to problems of living outside. It will bring comfort and pleasure to those who must remain inside. At a time when life seems to the patient to have stopped, when long periods of time must be lived under enforced institutional care, cultural interest are antidotes to discouragement, to fear, and to anxiety. For broader horizon, for richer emotional tone, for greater joy in living, institutional music programs can well be utilized as a sound public investment in good health.

Dr. William C. Menninger (of one of the country's most famous psychiatric institutions) has said: "Psychiatric hospital care should afford specific and continuous treatment, specific in that it is directed toward meeting the conflict of the individual, and continuous in that every contact that the patient makes throughout every day should guide him toward the same therapeutic goal".

These examples come from experiences with this kind of music therapy in the milieu therapy program at the Menninger Clinic Psychiatric Hospital, in Topeka, Kansas.

Case 1. A boy, aged 19, had uncontrollable outbursts of hostile, destructive behavior, boastfulness,

and an attitude of contempt for other people's opinions and rights. Coupled with this lack of control of hostility was an intense need to be accepted by the group and a longing for affection and warmth which he had never known. There was no question but that the hostility, directed toward both parental and sibling figures, prevented just the acceptance he needed so badly. He played a band instrument, and it was felt that use could be made of his interest in music to supplement the therapeutic program, which was designed to foster control of the hostility and increase the gratification he could get from inter-personal relationships.

To this end, participation in two aspects of the music program was prescribed by his physician. One of these consisted of daily lessons and practice at the piano with a music therapist who was a warm, motherly person. With a combination of gentleness and firmness she was able to engage his attention for increasing periods of time. She first chose exercises and selections in which he could pound and bang on the piano, and then gradually modified these as the need for such outlets diminished. Duets afforded her an opportunity to demonstrate to him the pleasure to be attained from cooperative efforts. When his aggressive behavior was sufficiently under control to permit more activity with the groups, he became a member of the patients' dance band. This was an activity he was interested in, yet he soon discovered that his behavior was so disruptive to the group that he could not continue as a member unless he was able to modify it. Helpful suggestions from the therapist and opportunities for leadership in those areas where his skills permitted helped him overcome the initial difficultits. Then he found the other patients in the band became genuinely friendly and even admiring of his musical ability. The relationship between control of hostility, gratification in personal contacts, and praise for real achievement was clearer from the experience itself than words alone could ever convey.

Case 2. A young woman, aged 23, had a different but no less useful experience with music therapy. She was impulsive, demanding, aggressive, pushed people's patience to the limit, and constantly provoked rejection. Hurt feelings and sulky behavior would follow, with no awareness that she had done anything to disturb, annoy or provoke the other person. Consequently, everyone was viewed as hostile, an enemy, and the cycle was started again. This had been going on all of her life and would be seen in its greatest intensity in relation to her mother, who rejected her.

Our first therapeutic goal was to increase her awareness of the ways in which she contributed to her own unhappiness, of how her behavior affected other people, of how she provoked rejection and then reacted to it with more hostility. Only after this goal was reached did we feel we could begin to help her understand the reasons behind her behavior and how she might change it to more satisfying ends. It was hoped that her interest in music could be used in achieving these goals.

Piano lessons were prescribed, not to increase her musical knowledge or ability, but to use the relationship with the music therapist to call her attention to the various facets of her behavior as they appeared during the lesson. In the course of treatment there was ample opportunity for this. The therapist's patience was tried again and again; the same simple mistakes were made repeatedly, pointed out to her, corrected, made again, then blamed on the therapist. She insisted on skipping necessary preliminaries and plunging into music far beyond her ability. If denied, she felt abused and deprived; if permitted to count failure in this way, she was not sufficiently protected. The hours for teaching and practice time were either

inconvenient or insufficient. Within the music therapy situation, one character trait and behavior pattern after another was directed to the patient, not to the music, and she dealt with things on the spot as they happened. Why these all appeared in such concentrated form in relation to music lessons it was difficult to say, but its value was obvious. Instead of many people dealing piecemeal with the problems, in a variety of situations, it was possible to concentrate the confrontations and suggestions in one person and one situation with all adjunctive to it. One might even say the psychiatrist was an adjunctive therapist in this case.

Case 3. A young man in his twenties was a very talented violinist. It was his talent on which his family doted and which was exploited by them. Over a period of a few years he had withdrawn from social contacts, developed many physical complaints, and begun to drink heavily. As his family's concern mounted, his symptoms increased. In the hospital it was necessary to help this young man find gratification by means other than his illness and the worry it aroused in his parents. It was also necessary to avoid any further exploitation of his talents except for his own gratifications. Playing for pleasure, his own pleasure, became the important thing and if it was not enjoyable, there was no need to do it. At the same time his symptoms afforded him no gratification while in the hospital, and a gradual substitution was made.

Case 4. An isolated, almost mute boy was unable to accept any companionship or to respond to friendly overtures. Listening to phonograph records in the presence of a music therapist led slowly to his being able to request his own selections. Occasional attendance at record concerts led him into contacts with other people. He was gradually able to extend these contacts.

It can be seen from these few examples that music can mean different things to different people, and in psychiatry perhaps more than in any other branch of medicine, the person rather than the disease must be the focus of attention. How could we possibly go about prescribing this kind of treatment for schizophrenia for example? Would we mean the schizophrenic who is withdrawn and mute, or he who is hostile and destructive, or suspicious and delusional, or guilt-ridden and depressed, or alcoholic, or grandiose, or hypochondriacal, to mention a few? Diagnostic labels are few but there is infinite variety in people.

Although the actual form of music therapy itself was not the same for any of the patients described in the example, difference in form is not the basis of its individual therapeutic value. Even the same activity can serve different ends. As an extreme yet simple illustration, let us take the learning of a new and standard piece of music, say Beethoven's familiar "Minuet in G". For the impulsive antisocial person it could be a stepping stone to conformity. There is a right way to play it and a wrong way. For the person who needs to find security in orderliness and perfection, attention can be directed to the correctness of the notes, and to the following of the dynamic markings, the pedalling, and the fingering, it can be a creative experience, a way of bringing pleasure to others through public performance, a way of establishing contact through sharing a common and familiar memory, and so on with many variations.

This is a partial answer to the question as to the difference between musical activity and music therapy. Music is therapy when it is subordinated to a definite treatment goal, when it is used in such a way as to fulfill a specific need, provide an outlet for tensions, or serve as a focus for personal relationships. But this would seem to present a paradox. Beethoven's "Minuet in G" is Beethoven's no matter what use is made of it, no matter whether the playing of it is a pleasure or a chore, a way of creating, or a way of receiving attention. How then can Beethoven's "Minuet" cure anyone?

In the answer to this question lies the essence of this type of music therapy; and, the answer is as simple as it is startling—the music alone does not cure. The music therapist, using the flexible medium of his special field, is the real therapeutic agent. It is he who uses the music in a particular way to achieve the particular treatment goals; thus, helping the patient make a real therapeutic experience out of what would otherwise be work or recreational activity. The atmosphere that the therapist creates, the relationship he establishes with the patient, the particular direction in which he turns his attention, change music activity into music therapy.

Mastery of the medium and understanding of the rehabilitation hospital program prepare the therapist to use a broad gamut of musical activities. Which particular ones are suitable will depend on the kind of institution and the kind of patient. For patients with tuberculosis a passive approach is needed, as with hospital-

wide radio with ear-phones, occasional quiet programs, music quizzes and simple instruments to play such as the auto-harp. For slow, retarded groups much elementary rhythm work is required, musical games which are simple, and dancing. For the crippled, such performances is indicated as can be mastered with coordination. In correctional institutions the potential socializing forces of music and the satisfaction of developing new talent are important. For mental hospitals, a broad range program is possible touching every phase, diversional, educational, spiritual, and as constructive occupation. The same values are potential for work with the blind or deaf with special approach for making contact and fitting the activity to the individual capacity.

The relationship of the therapeutic purpose and music assignment must be understood by the worker if he is to be an effective member of the therapeutic team. He must be at home with the professional terminology used in referrals, reports and histories. In mental illness he must know when it is good for the patient to be featured and given a spot of importance, when it is better for him to accept being only part of a group. He must recognize how to help a shy person find security in an activity, and an aggressive one to accept the disability of concerted effort with others. In the areas of neuromuscular and orthopedic handicaps he must understand muscular and joint functions, perceptual and sensory functions, and disabilities, and the danger of overfatigue. He must realize the extent of possible improvement and know how to manipulate the musical activity to help the patient release naturally and constructively. Understanding these principles of therapy is of equal importance with musical skill.

The Music Therapy Staff of the South Carolina State Hospital consists of a Director and Assistant Director. There are regular weekly classes in music appreciation and music listening, classes in theory and sight-singing, ensemble groups and various combos, music in the dining room, private lessons on various instruments and chamber music rehearsals.

Recitals are given in the auditorium. A patients' music club has been formed whose members strive to maintain the highest standards, that they may edify and educate others to an enjoyable appreciation of the beauty and cultural value of music in the hospital program.

The orchestra has been formed to provide a means of establishing a co-ordinated therapeutic, cultural experience for the patients; a means for acquainting the public directly with the problems of mental illness by integrating town musicians with hospital musicians; a presented opportunity for hospital personnel to share a common meeting ground with the patient thereby establishing closer relationships with them and the volunteers involved.

The South Carolina State Hospital is one of the few public mental hospitals in the South to have music therapy interns. The training program here accepts students for a six months clinical training internship during which psychiatric nursing classes are attended, assistance given in all areas of the hospital in order to receive a broader ancillary outlook, and opportunities afforded to participate in the research, training and development program made possible by the National Institute of Mental Health Grant.

As basic requirements in the rehabilitation of patients, various activities are arranged in the music therapy schedule. The music therapy club of about 20 patients, guided by the music therapy director, meet to discuss ways and means of promoting and encouraging equitable relationships between patients and hospital personnel in the establishing of a therapeutic environment. Utilizing group material, functions of the music therapy program include club meets, weekly ward and dining room music, listening hour, music appreciation, rhythm band, symphony orchestra, a cappella rehearsal, community sings, coached groups, rehearsals with various instruments, in addition to individual lessons. Medical interns, chaplains, affiliate nurses and music therapy trainees have opportunities to test and evaluate music therapy principles in varieties of treatment situations in order to learn their degree of applicability in the treatment program.

Music Clubs or other organizations such as the Lions, the Sertoma, the Rotary, the Junior League, the Women's Club and interested

groups, as well as professional groups, have in various communities in the past, all undertaken to do their part in helping to contribute the costly equipment, such as pianos, tape-recorders, accordians, band and orchestra instruments or victrola records, and even household furnishings to make our rooms appear warm and homelike.

Civic groups or persons who are civic minded can assist in the establishment of our South Carolina Hospital Music Therapy Department. Material support of projects can run from small specific projects to large highly specialized programs impossible to launch without the sponsorship of foundations or organizations of size and serious purpose. This has been successfully undertaken for many hospitals where music therapy was just being established. Trained and skilled professionals must plan and direct any method in the treatment program, but the assistance and active participation of unselfish and interested men and women is of tremendous value.

THE GREENVILLE COUNTY MEDICAL SOCIETY HISTORICAL SKETCHES GREENVILLE'S HOSPITALS

J. DECHERD GUESS, M. D.

The first hospital to be operated in Greenville was called the Soldiers Rest. It remained open for three years, 1862-1865. It was maintained by the community for sick and wounded Confederate soldiers.

In 1872, ten years after the opening of the first hospital, the second hospital in Greenville opened. It was a private, small hospital, or infirmary, which was owned and operated by Doctors James Marshall McClanahan and George E. Trescott. It must not have been a successful venture since it remained open for only one year.

The first hospital to occupy a building designed and built for it was the Earle Sanatorium. It was built and operated by Doctors T. T., Curran B., and Joseph B. Earle. It had 18 beds and a well equipped operating room. It was primarily a surgical hospital, operated to care for the growing surgical practice of the Earles. It continued in operation for 12 years and closed in 1911. Its closing was a gesture of goodwill and support to the new City Hospital, the precursor of the Greenville General Hospital.

Dr. W. C. Black operated a hospital with 14 beds and an equipped operating room during almost the same period. He also closed his hospital in 1911, and transferred his work to the City Hospital.

These two private hospitals made of Greenville an early medical center. Dr. Black and Dr. Curran Earle were equally ambitious. There was always considerable rivalry between them, and each possessed traits which gave the other some advantage. Dr. Earle was always the gentleman of the old school. He was very punctilious, quiet spoken, immaculately dressed, and very gracious. However, he was quick tempered and easily offended.

Dr. Black was rough hewn, rather blunt at times, overbearing, always a little careless in his dress, and he always had a cigar stuck deeply in his mouth. However, he was big hearted, and he was the medical hero of many people in the environs of the city and even more in the hills and mountains of the countryside.

General surgeons were accepted by their colleagues and by the public at that time as a superior type of general physician. This was, and still is to a considerable extent, a carry-over from the time in ancient Greece and ancient Rome when doctors were divided roughly into two groups, namely, physicians

This is the seventh of a series of articles, adapted from the book *A Medical History of Greenville, South Carolina*, written by the same author, and which was published by the Greenville County Medical Society in 1959.

who were also surgeons, or who did surgery, and physicians who did not. Surgery was not a specialty. It was only the more ambitious physician, with the greater initiative, and who was the more studious, who prepared himself, even in a limited way, to attempt more than empirical medical practice and more or less conservative midwifery. These men became surgeons.

The Corbett Sanatorium was built in 1908. It was operated by a corporation called The Southern Oaks Sanatorium Company. Its capital stock was $15,000. L. D. Corbett, Dr. J. Adams Hayne, and Dr. J. R. Rutledge were the incorporators. It was operated for the treatment of alcoholism. It had continued under its original ownership for about four years, when financial difficulties caused it to close. The county medical society was offered an option on the building, but it showed no interest. The Women's Hospital Board of Greenville, however, saw an opportunity, and took up the option and re-opened the hospital as Greenville's first general hospital on January 10, 1912. In the first month of operation, the hospital received 46 patients and discharged 31.

The purchase of the Corbett building and its re-opening as a general hospital was the culmination of 16 years of continuous effort to establish a general hospital in the city.

Interest in a public hospital was first aroused by two cases of typhoid fever which occurred in a group of transient workers who were living in boarding houses in the city. There was aroused a fear of an epidemic of typhoid—an occurrence which was not rare in South Carolina at that time. In 1895, in an editorial in the *Greenville Mountaineer,* it was said, "A charity that has become an absolute necessity is a city hospital with a casualty ward." A movement to establish such a hospital had been started about that time by the Knights of Pythias. In 1896, at a well attended, citizens mass meeting, the Greenville Hospital Association was organized. A most prominent and civic minded citizen, Mr. George W. Sirrine, was made chairman. A short time later a ladies auxiliary to the hospital association was organized and began efforts to raise money. Some five years later, the auxiliary was reorganized as the Women's Hospital Board of Greenville, probably because the original hospital board had been so dilatory in its efforts to establish a hospital. That same year, the auxiliary rented a room in the Earle Sanatorium for one or two charity cases.

In 1909, the Charity Aid Society, another women's group, was founded and it petitioned the city council to appropriate funds to operate an emergency hospital for the care of charity patients. The following year a small charity ward of two or three beds for the treatment of destitute sick people was opened in a room at the Salvation Army Citadel. The Salvation Army furnished food, shelter, and heat, and the Aid Society paid the nurse's salary. There was also a small operating room and a room for the nurses. An out-patient clinic and dispensary were maintained as a part of this elementary effort.

The opening of the City Hospital in the remodeled Corbett Sanatorium building was a tremondous forward step. After the opening, the Women's Hospital Board again became an auxiliary, this time the Hospital Auxiliary. As such it undertook the overseeing of housekeeping problems in the new hospital. The hospital was operated by a board of prominent citizens.

It had always been the wish of the Women's Hospital Board that the city should own and operate the hospital. The facility had been offered to the city for $20,000 in 1913. This was about one-half of the actual value of the plant. Finally, in 1917, the city did buy the hospital from the Greenville Hospital Association and refunded all contributions which had been made toward the original purchase and remodeling. The Women's Auxiliary applied its refund toward the construction of the first nurses' home. This was completed and occupied in 1919.

Now the hospital was under city control. Already the need for enlargement was pressing. The closing of both the Earle and the Black hospitals had directed the greater part of local surgical cases, both private and charity, to the new hospital. A bond issue for funds for enlargement was voted, and a new main building was completed in 1921. The hospital

now had 125 beds. The nurses' home was enlarged in 1928.

The pressure caused by a growing population, a lessening fear of hospitals, and a better trained medical profession did not let up. In 1935, the J. Marion Sims memorial wing was completed. This added 75 beds, in relatively deluxe private rooms. The hospital now had 200 beds. Because of the unspoken influence of these deluxe rooms, in a specially named wing, as contrasted with the real or imagined connotations of the name, "City Hospital," the name of the hospital was changed to the Greenville General Hospital.

In 1938, a wing was added to the nurses' home. In 1939, a surgical wing was added to the hospital. In 1940, the Sirrine Ward was completed. The hospital now had a capacity of 275 beds. It was again enlarged in 1944 to 343 beds by the addition of a basement and two floors.

The hospital was still too small. In 1945, the first action toward a major expansion was taken. A special advisory board of prominent citizens was set up to study and direct the movement. In 1947, this board proposed that the hospital be made a county facility instead of a city owned and operated institution. It proposed that the county put up one and a half million dollars, to be raised by a bond issue, and that the city put up the hospital properties and equipment and that these funds and buildings and equipment be turned over to an independent board of trustees which would operate the hospital on a non-profit basis for the benefit of the citizens of Greenville County. It was proposed that the Board of Trustees be self-perpetuating with members from the city, members from the county, and one member from at large. These recommendations were accepted by the city, and the proposed bond issue carried in the county. Steps were immediately begun to enlarge the hospital by the addition of a new building designed to accommodate a new cooking and dining facility, new ancillary laboratories, a new administrative wing, and five new floors containing private rooms, semi-private rooms, and small wards. This building was completed in 1953 at a cost of $5,000,000. The hospital now had 563 beds, plus the bassinets in the new born and premature nurseries. It is not only the largest general hospital in the state, but it is also the most completely equipped.

As a part of this expansion, the Allen Bennett Memorial Hospital, with fifty beds, was built in Greer on land donated by Mr. and Mrs. B. A. Bennett. The hospital was named in honor of their son, a young surgeon who had just completed his surgical training before he entered the Naval Medical Service in World War II. He and his ship were lost in the Pacific. Although separately named, the Greer hospital is a unit of Greenville General Hospital.

All of the early troubles of the hospital were not material ones. The operation of a public hospital was a new adventure to both the governing board and the medical staff. In the fall of 1916, the entire medical staff resigned because of friction between it and the Board of Trustees. The basis of the trouble was a local outbreak of difficulties similar to those that were showing up all over the country between lay hospital management and professional staffs. The voice and the influence of the staff in hospital management has gradually assumed a greatly lessened importance everywhere. However, the change in Greenville has been accomplished in the main without serious disturbance. The "strike," as it was referred to in 1916, did not last long. Mr. Frank Barnes in the *Greenville Story* refers to "Many prominent physicians engaging in a wordy newspaper war to try to straighten out differences" in 1917.

Dr. George T. Tyler moved to Greenville in 1912. He came to do a surgical practice. In 1913, he opened a small private hospital. This was probably needed at the time, and certain it was that Dr. Tyler was happier working there than he would have been in the City Hospital, with its inadequate equipment and its stringent finances. However, his hospital ultimately served its purpose and several years before he died, Dr. Tyler moved his private surgery to the Greenville General. He closed his hospital in 1935.

A Mrs. Montgomery also operated a private hospital for a number of years. She had a rather high class clientele, which preferred the greater seclusion afforded by this small hos-

pital. Dr. T. B. Reaves and Dr. Fletcher Jordan were the principal professional supporters of this hospital during its existence.

In 1920, the Salvation Army, which for a number of years had operated a home for unwed mothers, began a project to build a general hospital in Greenville. The hospital was financed chiefly by public subscription. A very concerted appeal was made to the textile industry for assistance. The response was generous, and the hospital was built. The Emma Moss Booth Memorial Hospital was opened with 72 beds and 40 cribs. For a time, it was the place to go in Greenville when one got sick or needed an operation. Its popularity, however, did not last.

The Roman Catholic Church became interested in placing a hospital in Greenville as a part of its increasing influence in the community. It bought the Salvation Army's Emma Moss Booth Memorial Hospital and renamed it, St. Francis Hospital in 1932. It has been operated by the nursing sisterhood, The Sisters of the Poor of St. Francis. The sisters have enlarged it to 120 beds, and they continue to purchase new equipment as needed. It has proven to be a kindly place in which to be sick. Present plans are to build an entirely new and enlarged hospital, and to convert the present plant into a convalescent hospital and nursing home.

The Hopewell Tuberculosis Association operated a small cottage type hospital just beyond the city limits for more than 15 years, beginning about 1915. The county finally became willing to assume the responsibility for the treatment of its tuberculous citizens. It authorized a bond issue to build a hospital and a special yearly tax to support it. The County Tuberculosis Hospital, with 75 beds, opened in 1936.

The Shriners' Hospital for Crippled Children opened with 65 beds in 1927. It was made possible by a contribution of $350,000 by W. W. Burgess, a wealthy citizen of Greenville. The hospital's operating expenses are paid by the Shriners, with a supplement contributed by the Duke Foundation. No patients able to pay their expenses are accepted for treatment. Only children under 14 years of age, of sound mind, and with an orthopedic condition that can be helped are accepted. About twenty-five new patients per month were accepted prior to about 10 years ago. Since the advent of the antibiotic drugs, the number of chronic osteomyelitis cases has decreased tremendously. Also the number of children crippled by poliomyelitis is steadily decreasing. The number of new cases which can be accepted by the hospital has greatly increased. Since the hospital was built, an auditorium was added in 1943 or '44, and a large out-patient clinic building was occupied in 1957.

A negro hospital, the Working Benevolent Hospital, was operated for a number of years by that fraternal order. It rendered a valuable service to the community at a time when colored beds at the Greenville General Hospital were insufficient to meet the demand. It had a white surgical staff since there were no qualified negro surgeons in Greenville.

Dr. E. C. McClaren, a colored doctor, built and operated a very nice hospital for a time. When facilities became adequate and when negro doctors were admitted to the staff of Greenville General Hospital, Dr. McClaren closed his hospital.

The Maternity Shelter opened with 10 beds in 1932. It was sponsored by the Women's Hospital Corps. It began in a small residence in a cotton mill community. It was designed to offer hospital maternity care to multiparous women who were not eligible for free care at Greenville General and who could not pay for private care there. It has increased its facilities and its range of service and its support vastly since it began. It is now an agency of the United Fund. It receives a county appropriation for medical care of indigent mothers, and it is affiliated with Greenville General in such a way that members of the hospital intern staff each do a tour of duty at the Maternity Shelter.

Dr. J. W. Jervey operated a 15 bed hospital for the care of his own eye, ear, nose, and throat cases for many years. He opened it in 1923. It closed after his death in 1945.

This sketch should not end without mentioning the city's most unique hospital and one that is almost lost to the recollection of its citizens. Somewhere there is a reference to the

"Old Pest House" which was on the old Chick Springs Road at about the turn of the century. This, then, was the ancient forerunner of the modern and well appointed contagious ward of Greenville General Hospital, but with as great a change in the character of the patients, no doubt, as in the facilities. The pest house was used for smallpox cases, mostly, among the poor, and Greenville has had no cases of smallpox within the writer's knowledge since his own last two cases in the nineteen hundred and twenties.

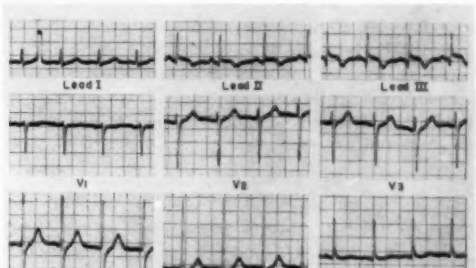
MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Subacute Bacterial Endocarditis

DALE GROOM, M. D.
Dept. of Medicine



Case Record—A one year illness in a young mother terminated in death at age 26. It was characterized by a low-grade fever, weight loss, weakness, transient headaches and visual disturbances, and cough with occasional hemoptysis and pleuritic pain. Early in the illness she had developed a loud mitral systolic murmur and thrill which persisted, as did a hypochromic anemia. At various times she was observed to have retinal hemorrhages, hematuria, and a small, tender petechial lesion (Osler's node) in the pad on one thumb. The clinical diagnosis of subacute bacterial endocarditis was never conclusively proven by blood cultures but intensive treatment with penicillin and streptomycin was followed by considerable improvement in the patient's condition on at least two occasions.

One of the complications which arose about midway in her illness was that of severe substernal pain radiating down the left arm. Subsequently, at the time this electrocardiogram was made, there was a transient elevation of her serum transaminase. The same pain recurred two months later but she again improved and was able to return home. Her final admission was occasioned by a sudden attack of left hemiplegia with nuchal rigidity and motor aphasia from which she died.

At autopsy her heart was dilated but weighed only 280 grams. The posterior leaflet of the mitral valve was thickened and on its free margin were small clusters of grayish nodules up to 5 mm. in size, thought to represent old vegetations. Several of the chordae tendineae of that leaflet were shortened and thickened while others were completely severed, rendering the mitral valve grossly incompetent. Evidence of old infarctions was found in the diaphragmatic wall of the left ventricle, (areas of fibrous scarring in the distribution of the posterior descending branch of the right coronary artery), in the left occipital lobe of the brain, and in one kidney. The aorta, the coronary and the cerebral arteries showed no appreciable atherosclerosis. Immediate cause of death was a large intra-cerebral hemorrhage of the right parietal lobe.

Electrocardiogram—The Q waves in leads II, III and aVF are not of major proportions but their combination with the S-T segment elevation (1.5 mm. in aVF) and the deep inversions of T waves is strongly suggestive of an acute injury to the diaphragmatic area of the posterior wall. Reciprocal S-T depression is minimal in leads aVR and aVL but fairly definite in V_4 where the T waves became quite tall and peaked in later tracings.

There is a regular sinus rhythm (rate 98) with normal P-R and Q-T intervals. Inversion of the P wave in aVL is probably due to the semi-vertical electrical axis.

Discussion—Myocardial lesions occur with sufficient frequency in subacute bacterial endocarditis to merit mention. Aside from the hypertrophies resulting from valvular damage, the myocardium may become directly involved in the inflammatory process by simple extension and invasion or by embolization of coronary arteries with consequent infarction. Also, a diffuse myocarditis fostered by hematogenous spread

of the micro-organisms has been postulated as an explanation of the congestive heart failure which sometimes appears in bacterial endocarditis. Localized septic necrosis of the papillary muscles and myocardium as well as of the valves may rarely account for conduction abnormalities or perforation of the interventricular septum or sinus of Valsalva.

The electrocardiogram in this case is indicative of acute infarction of the posterior wall which is of course consistent with the history of chest pain and the subsequent rise in serum transaminase. The atypical feature was that the S-T segment displacements persisted for several weeks, along with the evolutionary T wave changes typical of infarction, suggesting a prolonged destructive process. One of the few signs of posterior wall infarction in the precordial leads is the reciprocal S-T depression displayed best in V_1. The small Q waves in V_6 are probably those of normal septal activation.

With the patient's known embolic involvement of other organs, an embolus to the posterior (right) coronary artery remains the most likely explanation though obstruction or embolization could not be demonstrated later at autopsy. Subacute bacterial endocarditis is the most frequently recognized of the causes of coronary embolism which include the occasional aseptic thrombus and perhaps air embolism.

Doubtless the patient's advanced mitral insufficiency was caused mainly by the rupture of chordae tendineae during this acute illness, leaving insufficient time for development of hypertrophy of the left ventricle. Intrinsicoid deflections of R waves over the left precordium are well within normal limits and there is no indication of hypertrophy of any chamber of the heart.

Antibiotics have so altered the pathology of subacute bacterial endocarditis that one seldom sees the friable septic vegetations on which the autopsy diagnosis was classically based. Obviously the clinical picture and prognosis have changed, also. But a major gap remains between bacteriological cure and recovery of the patient, many of these patients still succumbing to relapses or complications of the disease.

Acknowledgement: I am indebted to Dr. Edward McKee of the Department of Pathology for help on the autopsy aspects of this case.

Valsalva maneuver as a diagnostic aid. (J.A.M.A. 170:787-791, June 13, 1959)

Two hundred and five selected office patients were given careful examinations following which a modification of the Valsalva maneuver was done. This consisted of having the patients strain against 40 mm. of pressure using an Asepto syringe connected to a Tycos manometer guage. The straining is maintained for ten seconds and blood pressure is determined before, during, and after the period of straining. Evidence of congestive heart failure is manifested by a failure to develop the normal fall during the period of straining and the normal rise after straining. Similar findings are noted with some obstructive valvular lesions such as mitral and aortic stenosis. Emphysema gave a diametrically opposite response. The test was felt to be valuable and as it was quite simple and easy to do, should be a part of the armamentarium of all physicians.

The 1955 model of patient is a different individual than the 1935 model. The later model is a better educated person, and much better informed about medical matters because of medical columnists, magazine articles, books, radio, and television. If he watches "Medic" on television he may even know how to operate. The gripes twenty years ago were that the other fellow did not cure him or at least not fast enough. The gripes of today are different. He tells you that the other fellow did not take any interest in him, was completely impersonal, hurried him through, told him there was nothing wrong with him, did not explain things to him or used medical jargon, and charged him too much. In brief, he looks upon us as scientists and mechanics and not as physicians in the true sense of the word. He would like to have sympathy and understanding in addition to the magic medicines and spectacular techniques; in other words, to be considered as more important than his disease. Dr. Joseph Collins, who had a great deal of experience as a patient, has written. "It is only human nature for the man who deals daily with bodily deformities and mental shortcomings to grow superior to his world. If he happens to be a big vigorous man himself, this sense of personal fitness easily breeds the arrogance, bored tolerance, facile condescension, and autocratic dogmatism with which physicians are often charged."

(From "Public Relations and the Patient" by William J. Butler, MD. Tuscon, Arizona. Printed in *The Michigan State Medical Society Journal, December,* 1958)

PRESIDENT'S PAGE

THE AGED

There are over 15 million people in the U.S.A. who are 65 years and above. Sixty-five is the retirement age, though it seldom applies to the physician, as you can count on your hand the number of medical doctors in South Carolina who have retired, and I doubt they would equal the number of fingers on both hands. Is this a good or bad sign? I would say it is excellent, for as long as one is occupied and mentally alert he is happy.

There are three classes of the oldster with whom we come in contact:

1. The sick oldster
2. The frail or fragile oldster who without good attention would become sick, and
3. The well oldster, who, if guided by a positive health program should be able to solve most of his own problems.

The doctor realizes from his experience that the stigma and diseases usually associated with the aging are due to the impact of stress and environment.

Hardening of the arteries is no worse than softening of the arteries with the loss of the will to live.

Loneliness, rejection, loss or lack of interest, neighborless, and no occupation will result in emptiness for the aged, meaning no desire to live. We must prevent these manifestations.

What are we doing about the aged? Geriatrics or gerontology is certainly a responsibility of the physician, since we are the ones who have caused the increase in prolongation of life. The reduction in childhood mortality and better care for the premature and infant is the beginning of the older citizens. Better and purer foods have an important role in adding to the span of life. Chemotherapy and antibiotics contribute their part.

There are no diseases specific to the aged, but we have diseases among the aged. For instance, there have been 98 arteriosclerotic heart diseases, including coronary, in children under five years of age, and these we find in every age bracket thereafter.

Voluntary health insurance is the method the A.M.A. sponsors in helping to take care of the elder citizens. Thirty-nine per cent in the years 65 and over now carry health insurance. The breakdown in this group is found in the bulletin, "Progress in Health Services - Health Information Foundation", (8: Jan. 1959) (420 Lexington Ave., N. Y. 17, N. Y.)

GOALS OF THE A.M.A. ON AGING

(1) Adequate medical care at the lowest practical cost for those who are ill.
(2) Promotion of better understanding and wider use of restorative services on behalf of those who are disabled.
(3) Encouragement of activities, both group and individual, for the prevention of illness among all older persons, and
(4) The promotion of longrange positive health programs which will increase the over-all capacities of persons to live active, meaningful lives in their later years.

Environment is a big factor in dealing with the aged. Chronically sick older people can be treated at home if they desire to remain there with adequate nursing, physiotherapy, occupational therapy and proper medical guidance. Determine where the interest of the individual lies and apply the therapy games, knitting, sewing, religion, handicraft, birdwatching, radio, television, reading, etc. One should certainly visit St. Petersburg, Florida, to see these old timers play baseball, bowl, golf, swim, croquet, fish, shuffleboard, walk and dance. You would realize they have a useful place in this universe. A wrinkled skin need not be a wrinkled mind, heart and soul.

William Weston, Jr.
President

Editorials

PROGRAM FOR THE MAY MEETING

Winter has come, spring will not be far behind, and the Annual Meeting of the Association at Myrtle Beach in May will be upon us.

Perhaps now is a good time to reflect a little bit on the programs at the Annual Meeting. Year after year a hard working program committee produces for our members an array of visiting speakers of eminence, ability, and sometimes of eloquence. Year after year these speakers face the dismal prospect of delivering their addresses to a corporal's guard of members who have resisted the temptations of the fleshpots which are to be had at every meeting. It is a discouraging experience for a noted physician to find such a welcome when he has traveled far and spent much time without any material recompense. It would seem to be good manners at least to have our members listen attentively and in number, even if the subject of the particular speaker may not be of too direct interest to them.

One wonders what the secret is for providing a good attendance. Frequently when a speaker is a bit on the fringe of some medical borderland, he draws a much bigger audience than does the man who is established, experienced, and even famous. It is curious to wonder what brings most of our members to the meetings. Periodically one hears complaints that there is not enough post graduate instruction and that something must be done about it, but when such instruction is provided, the indignation of the complainer has subsided, and he is not to be found.

We go back to Myrtle Beach this year, where the perilous pleasures of the beach may be too distracting for the scientific inquiring mind. It will be a pity to have the kind of neglect that has been given to speakers in the past passed on to the outstanding men who will appear this year. The current program committee has worked hard to secure good talent. Among the speakers will be Dr. George Anderson of Providence, Rhode Island and Dr. Robert A. Cosgrove of Jersey City. Both of these will give addresses and will also participate in the panel on perinatal problems. Similarly Dr. Edward Krementz of New Orleans and Dr. A. R. Curreri of Madison, Wisconsin will speak and will be active in a panel on Chemo-Therapy and Hormonal Therapy of Cancer. On the interesting subject of geriatrics, Dr. E. V. Allen of the Mayo Clinic and Dr. A. C. McCarty of Louisville will contribute their knowledge, as will Dr. Kenneth Appel of Philadelphia, a really brilliant speaker and an exponent of middle of the road psychiatry. His paper will be on "Basic Psychotherapy". Dr. Allen will present a paper on "The Natural History of Arteriosclerosis".

A panel discussion on cardiovascular disease will be brightened by Dr. Bruce Logue of Atlanta and Dr. Harry Muller of Charlottesville. A number of our own members will participate in these panels and act as moderators in most cases.

A new departure this year is a group presentation from our own members. The opthalmologists are getting together a single presentation on "Glaucoma in General Practice". Dr. Howard Stokes is responsible for the production. It is hoped that if this presentation is well accepted other specialty groups may undertake a similar sort of thing for future programs.

These distinguished visitors and members will undoubtedly offer an excellent program. It deserves an excellence of attendance.

STATE ASSOCIATION ANNOUNCES A NEW INSURANCE PROGRAM OFFERING TAX ADVANTAGES

The Commissioner of Internal Revenue and the courts have ruled that under the 1954 Internal Revenue Code, form No. 162, premiums paid for a business overhead expense insurance policy are tax deductible. The benefits payable under the policy are to cover monthly expenses actually incurred in the operation of your office, thus, making this deduction possible.

The State Association's insurance committee, headed by Dr. Clay Evatt, reviewed several insurance

programs, and recommended to the Council that the Association sponsor this business overhead expense plan. This plan is now being submitted to the membership for their individual consideration.

The business overhead expense policy is a very inexpensive means of maintaining your office during a period of disability, as the premium rates are decidedly less than those charged for disability income insurance. The policy will reimburse you up to 75% of your normal office operating expense, and in the case of a partnership, the company will pay the insured's proportion of such expense.

The insurance program will be administered by The General Agency, 11 State Street, Charleston, South Carolina, an independent insurance firm, specializing in association group coverages. It will be their responsibility to install the group program, handle all general correspondence, billings, claims, etc. The insurance program is being underwritten by one of America's leading insurance companies, The Continental Casualty Company.

Each member of the Association will receive, by mail, a brochure explaining the insurance program, and a representative of The General Agency will personally contact him to discuss the details of the plan. You are urged to give this your consideration, for if 50% of our members apply during the initial enrollment period, the company guarantees to issue a policy to each applicant regardless of his prior medical history.

COLLEGE POLICY TOWARD COUNTY INDIGENT PATIENTS TO DETERMINE HOSPITAL STANDARDS GENERALLY AVAILABLE TO CHARLESTON COMMUNITY

Wm. H. Prioleau, M. D.
Charleston, S. C.

Decisions to be made within the next few months concerning the care of Charleston County indigent patients will determine the scope and standards of hospital facilities to be generally available to the community for the foreseeable future. For many years the Charleston County indigent patients have been hospitalized at the Roper Hospital and attended by the faculty of the Medical College. This arrangement has enabled Roper Hospital to serve the community as a highly accredited hospital with well-developed departments in the specialties. It has also made available to the Medical College a large group of patients of great value in teaching medical students and the training of interns and residents.

This arrangement had to be discontinued several months ago when the Roper Main Building, in which these patients were housed, had to be closed as it failed to meet the requirements of the Joint Commission on Accreditation of Hospitals. The Medical College Hospital agreed to accept these patients as an emergency measure so as to prevent a situation which would have had serious consequences from the standpoint of the College and the community. At the same time it stipulated that it would not assume responsibility for their care beyond January, 1961 unless County Council by that time had made permanent plans for their hospitalization. County Council has engaged the services of a team of medical consultants to make a survey of the hospital needs of the community with particular reference to the care of the indigent patients and the maintenance of an Emergency Room.

Indigent patients of sufficient number are of great value in the basic functioning of a general hospital. This type of patient is important in a teaching program and is essential for residency training in the various specialties. Charleston County indigent patients are supported by local taxes. They should be hospitalized in such a manner that they can be used for educational and training programs—which would enhance the scope and standards of hospital facilities generally available to the community. Any new construction by the county should be in proximity to Roper so that a close working relationship can be established between the two institutions. Effort should be made to retain the desirable features of the recent arrangement which served to the benefit of the community over many years, and to remove the more controversial features, particularly those dealing with cost allocation. Such an arrangement would enable Roper Hospital to continue to provide the community with the services of an accredited hospital with well-developed departments in the various specialties. It would also permit Roper to continue to be of value to the Medical College in its educational program by providing a block of indigent patients under conditions satisfactory for teaching and resident training.

The need for a well-equipped and well-staffed community hospital is becoming more apparent every day. While the Medical College Hospital is a valuable asset to the community in making available certain skills and facilities on a referral basis, it was constructed to serve the state and it cannot be expected to relieve the community of the necessity of providing hospital facilities to meet its normal requirements. Physicians on the voluntary faculty who are in private practice are now finding it difficult to secure admission of their patients to the Medical College Hospital. The facilities of the Medical College Hospital will become less available to the residents of the community as it

becomes better established as a referral hospital on a state-wide basis.

The Medical College would render an invaluable service to the community if it would take an unequivocal stand that the care of Charleston County indigent patients does not come within the province of the state hospital, except as an emergency measure. That there is needed a statement by the Medical College concerning its present policy regarding the care of Charleston County indigent patients is clearly indicated by the proceedings of the Medical Society of South Carolina and reports of conferences by representatives of the County Council, the Medical College and the Roper Hospital. A statement of recognition by the Medical College that the care of Charleston County indigent patients is within the province of the community hospital would be of particular value if it were made in time to be taken into consideration by the consultants engaged by County Council to make a survey of the hospital needs of the community. It would pave the way for a suitable arrangement between County Council and Roper Hospital for the care of Charleston County indigent patients in such a manner as to raise the scope and standards of hospital facilities generally available to the community. It would enable Roper to continue a close affiliation with the Medical College and take an important part in its educational program.

BLUE CROSS . . . BLUE SHIELD

BEDS—NOT ENOUGH? TOO MANY?

Richard J. Ackart, M. D.

"The public should exercise better control over its capital investment in hospitals. . . . The quality of care is, of course, in the hands of physicians and the professions concerned with hospitalization. . . . But the public is entitled to control the expenditures. . . . Any community should view with alarm the expansion of hospital facilities except in response to a recognized immediate or future need"[1] Published in the year 1930, the foregoing statement referred to widespread activity in hospital construction during the preceding decade, when community coordination was not taken seriously. Times have changed—hospital planning now is, or indeed should be, a primary concern not only of local hospital bodies but of authorities and organizations which are in a position to effectuate state-wide coordination—The Medical Society of Virginia, for example.

Because health care is such a fast-changing complex of activity in America, with different developments pointing in different directions, the future of hospitals and of medical practice cannot be foreseen. We cannot rest assured that the public will continue to pay whatever is required to maintain health care on a voluntary basis. On the other hand, we need not agree with those who say that we will all be taken into socialized medicine in the next few years. It depends on what doctors, hospital people, and others in the health field do in the meantime. The doctors of each state, individually and—perhaps more effectively—through their medical societies can influence the future of health care by influencing the future development of hospital facilities.

Not too many years ago the hospitals of Virginia did a remarkable job of meeting needs for hospital-care despite what were then properly recognized as acute bed-shortages. But many beds have been constructed in the interim, and it might be that the era of shortages has come to an end. There is reason to believe that it has. As a matter of fact, there is a possibility that Virginia will have a costly surplus of beds if too many of those already in sight are put into service too soon; careful state-wide planning is needed if we are not to go from one extreme to the other.

There is a plethora of evidence that the rising costs of hospitalization are making more and more people believe — rightfully or wrongfully — that those costs should be placed under other than voluntary regulation. Because of the constant over-head expenses involved, each and every hospital bed beyond absolute need—be it unused or misused—unnecessarily adds about $7,500 to Virginia's total annual hospital bill. Accordingly, a major factor in holding down future hospital costs will consist of not building more hospital facilities than are actually needed.

Many of the existing hospitals in Virginia draw their patients from a wide area. Therefore, bed additions by one hospital may reduce the patient load of a number of other hospitals throughout the area, leaving these other hospitals with a Hobson's choice—to accept the expense of supporting beds in idleness, or to accept as bed-patients those whose condition does not require or justify bed-care. In either case the over-all hospital bill for Virginians increases.

Not only hospital beds but also hospital services should fit into the state-wide, coordinated health-care scheme. The addition of expensive hospital services when such services are available in adequate measure in neighboring hospitals is just as wasteful of the health-care dollars of Virginians as is the addition of unnecessary beds.

How many existing beds are—or may be—unnecessary? The fact that the existing beds are kept in use is no criteria on which to base an answer, nor is the fact

that a given hospital may be unable to admit all comers on a given day. An apparent need for more beds might well be satisfied were the hospitals to provide proper facilities for private ambulatory patients; conversely, construction of such facilities might well prove that many existing beds are unnecessary. All too few hospitals in Virginia offer proper facilities to which physicians can refer their private ambulatory patients for x-ray examinations, laboratory tests, and diagnostic work-ups. These private vertical patients should, of course, be received in adequate waiting rooms on an appointment basis, and the doctor should be provided with suitable space for consultations. We must discard the anachronistic idea that out-patient facilities are for indigent patients.

The various health-care activities of our hospitals need to be orchestrated not only in local communities but also on a regional and on a state-wide basis. Virginia must, of course, have enough hospital beds, but care should be taken to avoid the needless expense of too many. In its attempt to control its capital investment in hospitals, the Virginia public leans heavily upon the advice of Virginia doctors; accordingly, through our various organizations and societies, we should subject existing hospital facilities and services to a thorough-going and objective analysis in order to give truly astute advice to the public we are dedicated to serve.

If we consider that socialized medicine is not a good system, and is not inevitable, then we are committed to positive programs of study of the shortcomings of our present system, and positive programs toward the alleviation of these shortcomings. Because of the number of dollars involved, and because of the public's obvious concern, perhaps the best place to start is with our hospital facilities and services.

1. Rorem, C. Rufus. The Public's Investment in Hospitals. University of Chicago Press, 1930, p. 216.

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NEWS

COLUMBIA MEDICAL SOCIETY

The Columbia Medical Society held its Annual Meeting for the Election of Officers on Monday, December 14th, 1959. Dr. W. A. Hart was named President for 1960. The Society for the first time elected a President-Elect, Dr. Weston C. Cook, who will become President in 1961. Other officers elected were: Dr. John H. Young, Vice-President; Dr. C. R. Sloan, Secretary; Dr. Waitus O. Tanner, Treasurer; Dr. R. P. Watson, Editor of *The Recorder*.

Dr. J. William Pitts was elected to membership on the Public Relations Committee, and Dr. Lewis Pitts was elected to membership on the Board of Censors. The following were elected to serve on the Executive Committee: Dr. C. T. Weston, Dr. John Holler, Dr. Kirby D. Shealy, and Dr. Richard J. Kahaly.

Drs. M. W. Cheatham and H. F. Hall were elected Delegates to the South Carolina Medical Association. Alternate Delegates elected were: Dr. C. F. Crews, Dr. R. G. Latimer, Dr. C. K. Lindler, and Dr. H. A. Skinner.

The guest speaker for the February Scientific Meeting of the Columbia Medical Society was Dr. Edward H. Rynearson, Mayo Clinic, Rochester, Minnesota. Dr. Rynearson spoke on the subject "True Hyperinsulinism versus Functional Hypoglycemia".

Dr. George W. Brunson of Columbia also spoke at this meeting, his subject being "Pitfalls of Radiology".

DR. COCHRAN NAMED CHAIRMAN FOR HEALTH CARE OF THE AGED

An organizational meeting of the State Joint Council for Health Care of the Aged at Columbia on December 9 elected Dr. William N. Cochran of Spartanburg as its first chairman.

Initiated by the South Carolina Medical Association, the Council is composed of representatives from the medical group, the South Carolina Dental Association, the South Carolina Hospital Association and the South Carolina Association of Nursing Homes.

The council's general aim is the research and solution of medical economic and social problems facing the state's aged population.

During an hour-long session at the Hotel Columbia, the Council named Dr. Neill W. Macaulay of Columbia vice chairman and elected Miss Grace S. Southerland of Myrtle Beach secretary.

Dr. Cochran represents the Medical Association, Dr. Macaulay the Dental Association and Miss Southerland the Nursing Home Association.

A steering committee was appointed to map out a specific program for the Council which will work in conjunction with the National Joint Council. Members named were:

Dr. R. L. Crawford of Lancaster, immediate past president of the South Carolina Medical Association; M. L. Meadors of Florence, executive secretary of the Medical Association; Miss Esther Touchberry of Lancaster, representing the Hospital Association; Dr. J. I. Waring of Charleston, editor of the Journal of the South Carolina Medical Association, and Miss Southerland.

Earlier, Dr. G. F. McDaniel, director of the Division of Disease Prevention of the State Board of Health, said persons over 65 years of age represent about 7 per cent of the population of South Carolina.

He added that the board staff is preparing other statistical material aimed at aiding in the campaign to alleviate problems created by an increasing aged population.

Dr. McDaniel said the board is conducting pilot studies in four counties on home nursing programs for aged persons who are being cared for by their families.

"I think we're going to find," he added, "that this may be a great help in one area of this problem."

Dr. Cochran noted that a Legislative-Governor's

Committee headed by Rep. Martha Fitzgerald of Columbia is delving into the same problem and suggested that the Council offer its full aid and cooperation to the legislative group.

BIDS SOUGHT

The Board of Trustees of the Laurens County Hospital has called for sealed bids on the construction and equipping of a $360,000 addition.

Board Chairman Marcus S. Boyd said bids were to be opened January 6 in the office of the hospital administrator.

Under consideration are a 16-bed nursing unit, surgical x-ray suites, and a boiler room. About half of the cost will be met by federal funds.

WOODRUFF GETS NEW PHYSICIAN

Dr. Oliver E. Gilliland, who has practiced medicine at Enoree for the past two and a half years, will move his office to Woodruff, he announced.

He is a graduate of Louisiana State University and the Medical School of LSU.

His office will be in the Woodruff Building on S. Main St.

MEDICAL COLLEGE GETS $108,000

The Medical College of South Carolina and the Medical College Hospital are recipients of a $108,000 grant to assist in a program to train physicians in the field of neurology.

The grant was made by the National Institute of Neurological Diseases and Blindness.

The renewal of support for three more years starting in May, 1960, assures continuation of the program. The program was begun in 1956.

DR. CLAYTOR JOINS STAFF AT VA HOSPITAL

The appointment of Dr. Philip P. Claytor as a staff physician at the Columbia Veterans Administration Hospital was announced by the management.

Dr. Claytor, a native of South Carolina, received his M. D. degree from the Medical College of South Carolina in 1955. He served a 12-month rotating internship at the Medical Center Hospital in Charleston.

He served in the Air Force during the Korean Conflict.

Prior to his appointment, he was engaged in private practice in York for approximately two and one half years.

Gordon T. Wannamaker, M. D., diplomate of American Board of Neurological Surgery, announces the opening of his office in the practice of neurosurgery at 134 Rutledge Avenue, Charleston.

Dr. John L. Valley of Pickens was to retire on the first of the year after devoting 52 years and seven months of his life to the service of the citizens of Pickens as a physician.

Loved by all in the county and recognized often for his devotion and service, Dr. Valley will begin his 76th year of life by traveling throughout the United States visiting friends and relatives.

Dr. Valley was born January 23, 1883, in Michigan and completed his schooling in Tennessee, beginning the practice of medicine on May 28, 1907. In March of 1908, he came to Pickens and has been there ever since. June 1, 1949, was designated as "Dr. Valley Day" in Pickens and a handsome plaque inscribed "in honor of a great humanitarian, for his unselfish service with appreciation, love and devotion from his friends." Dr. Valley stopped delivering babies over a year ago saying it was too much night work for an old man but he estimates he has delivered approximately 6,700 children during his practice. He and his son, Dr. Tom Valley, have shared an office in recent years.

Long active as a Mason, Dr. Valley was potentate of Hejaz Temple when the Shrine Bowl game was inaugurated in Charlotte, N. C., in 1937. The first year's gate, donated then as now to the Greenville Crippled Children's Hospital was $19,000.

Dr. Valley was a member of the Pickens Town Council for 32 years and helped inaugurate the Board of Health. He was also head of the Red Cross for a number of years.

Carter P. Maguire, M. D. announces the removal of his office to 134-A Rutledge Avenue, Charleston, S. C. Plastic and Reconstructive Surgery.

S. C. MEDICAL EXAMINERS LICENSE 21 APPLICANTS

The South Carolina State Board of Medical Examiners licensed 21 applicants by endorsement at a meeting in December in Columbia, Dr. H. E. Jervey, Jr., secretary, has announced.

Those approved by the board include Dr. M. Janet Alexander of Erskine College. A graduate of the Woman's Medical College of Pennsylvania in 1917, she was a medical missionary in Pakistan for a number of years.

Dr. Jean D. Bayless of Ridgeland, who will do general practice. Doctor Bayless is a graduate of the Rochester School of Medicine and Dent., 1957.

Dr. Clark S. Collins at Greenville, Columbia University's College of P and S, 1951. He took a residency in Otolaryngology at Mass. Eye and Ear Infirmary in Boston.

Dr. Hiram B. Curry at Charleston, Medical College of S. C., 1950. Doctor Curry is a resident in neurology at the Medical College of South Carolina.

Dr. John T. Daves at Columbia, graduate of University of Maryland School of Medicine, 1917. Doctor Daves is with the Veterans Hospital.

Dr. Thomas E. Edwards at Columbia, graduate of University of Tennessee, 1946. He will finish a residency in orthopedics January 1 at Columbia Hospital.

Dr. George W. Galloway, Jr., at Columbia, graduate of University of Tennessee, 1958, formerly licensed

in Mississippi, and will do general practice at 3201 Millwood Avenue.

Dr. Joseph E. Greene of Greer, graduate of Medical College of Georgia, 1949, and has a general practice.

Dr. Byron R. Lewin of Crescent Beach, graduate of McGill University, 1934, and has been practicing medicine and surgery in Claremont, N. H. for the past 22 years.

Dr. Richard B. Maxwell, Jr., at Myrtle Beach, graduate of Cornell University, 1945. He took a residency in medicine at New York Hospital.

Dr. Harry C. Oard of Charleston, graduate of Yale University School of Medicine, 1928. He is district medical officer for Sixth Naval District.

Dr. Kenneth N. Owens of Aiken, a graduate of the University of Colorado School of Medicine, 1948. He took a residency in Obstetrics-Gynecology, and recently was discharged from the army, having served in the Medical Corps since 1948.

Dr. William R. Purcell of Charleston, a graduate of the University of N. C. School of Medicine, 1956. He is taking a residency in pediatrics at the Medical College in Charleston.

Dr. Ronald L. Redfield of Oil City, Pa., a graduate of Jefferson Medical College, 1934. He took a residency in surgery in Buffalo, N. Y., and will locate in South Carolina.

Dr. Robert N. Schneiderman of Beaufort, a graduate of Northwestern University, 1955. He took a residency in dermatology and presently is at the U. S. N. Hospital in Beaufort.

Dr. Claude A. Smith of Columbia, a graduate of Jefferson Medical College, 1953. He recently finished a residency in radiology at Duke and is now at Columbia Hospital.

Dr. Suzanne H. Sword of Beaufort, a graduate of N. Y. Medical College, 1956, who will do general practice in Beaufort.

Dr. Harry D. Tripp of Columbia, a graduate of Northwestern University, 1930, now on the State Hospital staff.

Dr. Joseph T. Wearn of Cleveland, Ohio, a graduate of Harvard Medical School, 1917, now dean of Western Reserve University School of Medicine in Cleveland. He plans to live in Yemassee when he retires.

Dr. Theodore S. Wedde of Rock Hill, graduate of College of Med. Evang., 1937. He took a residency in pathology and now is at York County Hospital.

Dr. William F. Young of Sumter, graduate of the University of Pennsylvania School of Medicine, 1954. He recently finished a residency in pediatrics at Childrens Hospital of Philadelphia.

Successful candidates of 23 applicants for licensure by written examination, will be announced later, Doctor Jervey said.

Lynn Derrick, M. D. announces the opening of his office for the practice of General Medicine at 1822 Washington St., Columbia.

DR. WYMAN HEAD OF DOCTORS

Dr. Joel Wyman, Anderson skin specialist, took office January 1, as president of the Anderson County Medical Society. He succeeds Dr. William Lummus.

Others elected include Dr. Charles Browne, vice president; Dr. Thomas A. Collins, secretary; and Dr. J. W. Jackson who was re-elected treasurer.

Retiring officers include Dr. Jimmy Young, vice president; and Dr. Robert G. Thompson, secretary.

DR. JOHN WORKMAN TO STUDY ANESTHESIOLOGY

Dr. John Anderson Workman, native of Woodruff, will enter Duke University around the first of the year to study anesthesiology.

Dr. Workman has been associated with Dr. B. J. Workman, Sr. and Dr. B. J. Workman, Jr. at Workman Clinic since 1953.

He graduated from Wofford College in 1940 and the Medical College of South Carolina in Charleston.

DR. LIPPERT IS AREA CHIEF OF SURGERY

Dr. Karl M. Lippert, chief of surgery of the Veterans Administration Hospital in Columbia since July 1946, has been named Area Chief of Surgery for Veterans Administration Area 7.

In the new post, Doctor Lippert will be chief of surgery for the Veterans Administration in Ohio, Indiana, Kentucky, Michigan and Illinois. He will take over the new position, with headquarters at Columbus, Ohio, Jan. 23.

Doctor Lippert began his private practice in Lancaster in 1938, and in 1942 became chief of staff of the Marion Sims Hospital in Lancaster.

His Army service began in 1942 as chief of surgery, 60th Station Hospital, Mediterranean theater, and continued until 1946, at which time he joined the Veterans Hospital here. He rose from Captain to Colonel in the Army, and has received the Bronze Star.

Doctor Lippert is a graduate of the Liberal Arts and Medical College of the University of Cincinnati, having been awarded the A. B. degree in 1928, the M. B. in 1932, and M. D. in 1933. He interned at Cincinnati General Hospital. In 1934 he was assistant resident pathologist at Vanderbilt University and from 1934 to 1938, resident in surgery, at the Medical College of Virginia.

He is a member of the First Presbyterian Church, a senior active member of the Five Points Rotary Club, a member of the Executives Club and a Mason. Doctor Lippert is listed in Who's Who In The South 1959. He has had 28 articles printed in medical publications with three to appear.

He is an affiliate of the following medical organizations: Fellow American College of Surgeons, Fellow International College of Surgeons, Diplomate American Board of Surgery, Diplomate American Board of Thoracic Surgery, Fellow American Association Traumatic Surgeons, Fellow American Association of

Geriatrics Service Fellow, American Medical Association, South Carolina Medical Association, Columbia Medical Society, member of past president, South Carolina Surgical Society, listed in directory of Medical Specialists, consultant in surgery to South Carolina State Hospital and visiting staff Columbia Hospital.

Vacancy, Whitten Village, for qualified medical doctor. Preferably young man. Experience pediatrics or psychiatry important but do not supercede good background, and not required. Early promotion to Superintendent if desired and acceptable to Board of Trustees. Salary and other benefits to be made satisfactory. Three good assistants now serving. New, well equipped hospital on premises available one year hence. Communicate with Superintendent, Whitten Village, Clinton, S. C.

DR. CARDWELL REAPPOINTED TO VA HOSPITAL POST

Dr. Edward S. Cardwell has been reappointed chief of laboratory service at the Columbia Veterans Administration Hospital according to Thomas B. May, hospital manager.

Dr. Cardwell served the hospital as chief pathologist from May 1949 until February 1956.

Dr. Cardwell received his M. D. degree at the Medical College of South Carolina in 1934, served an internship at Columbia Hospital in 1935 and as pathology resident at the Medical College. He was in general practice in Columbia from July, 1936, to July, 1937, and taught in various medical schools from 1937 to 1941.

He served in the armed forces from July 12, 1941, until March 6, 1946, and was assistant professor of pathology at the University of Georgia Medical School from January 1, 1947, to July 1, 1948. He was pathologist in Greenville from July 1, 1948, to May 17, 1949.

Dr. Cardwell is a member of the American Board of Pathology, the Columbia Medical Society, the South Carolina Medical Association, the American Medical Association and the South Carolina Society of Pathologists.

DOCTORS OPEN OFFICE IN CENTRAL

Dr. E. G. Shealy and Dr. G. W. Smith, who have an office in Easley, have also opened an office in Central.

Both of these young doctors have recently finished services with the United States Army.

Dr. Shealy is a native of Batesburg, and attended Presbyterian College and the Medical College of South Carolina.

Dr. Smith is from Pickens County. He is also a graduate of the Medical College.

DR. SHEPHERD ACCEPTS POST

Dr. Fred P. Shepherd of Aiken, plant physician for the Du Pont Company at the Savannah River Plant, has accepted a post as medical director of the Louisville DuPont Works in Louisville, Ky.

S. C. NATIVE NAMED U. S. DOCTOR OF '59

Dr. Chesley M. Martin, a South Carolinian who devoted most of his 70 years to the little Oklahoma town of Elgin, is the American Medical Association "Family Doctor of the Year."

Dr. Martin, who was born on a plantation near Anderson, S. C., has 44 years of practice behind him. He still works a 72-hour week which includes helping 25 Comanche Indian families as their "medicine man." He has delivered 2,500 babies in his career.

The AMA says he "typifies the thousands of general practitioners who have dedicated their lives to the practice of medicine and who have given exceptional service to their communities."

Eleven years ago, Dr. William L. (Buck) Pressly, a native of Due West, S. C., was named "Family Doctor of the Year" of 1948. His father was a professor of Greek and Latin at Erskine College. The son played professional baseball to raise money to finance his medical education at Emory University.

MEDICAL COLLEGE ALUMNI FORM AID FOUNDATION

A Medical College of South Carolina Foundation was formed recently at a meeting of alumni of the college in Atlanta.

An announcement by Dr. Jack C. Norris, secretary of the College's National Alumni Association, said the purpose of the foundation will be to promote the interest of the Medical College in medical research, education and public service and to receive contributions for that purpose.

Dr. Kenneth M. Lynch, president of the Medical College, made the principal address at the annual dinner and was presented with the Diamond Jubilee Gold Key of the Southern Medical Association.

Hosts for the meeting, held at the Academy of Medicine in Atlanta, were Dr. Jack C. Norris, Dr. Major Fowler, Dr. Samuel Norwood and Dr. Calvin Stewart.

The more than 100 alumnus and friends of the Medical College in attendance became charter members of the new foundation.

The South Carolina Medical Association urges you to

FIGHT FORAND

Send a handwritten letter to your congressmen and any others who may have a voice or a vote.

NEUROLOGY STUDY GRANT IS RECEIVED

The National Institute of Neurological Diseases and Blindness has awarded a grant of $108,000 to the Division of Neurology of the Medical College and Medical College Hospital.

The purpose of the grant, to extend over a three-year period, is to assist in the support of a program to train physicians for teaching and research careers in the specialty of neurology.

The training program, under the direction of Dr. Rhett Talbert, assistant professor of neurology at the Medical College, was begun in 1956 and has received support from the National Institutes of Health. The renewal of support beginning in May, 1960 assures continuation of the program.

In addition to supervised experience in clinical aspects of neurological diseases, the program provides advanced training in the basic science aspects of anatomy, physiology and pathology of diseases of the nervous system. At least three years of training after completion of internship are required to qualify the physician for certification in this specialty.

Four young physicians, all graduates of the University of North Carolina School of Medicine, will open practice in Hartsville during the coming year.

The four doctors will encompass the fields of internal medicine, pediatrics, obstetrics and gynecology.

Three of them will complete their residency requirements at the North Carolina Memorial Hospital in Chapel Hill, N. C. next June 30. The fourth will finish his service with the Navy Medical Corps next November.

All will be eligible for certification by the American boards of their respective specialties. The physicians are as follows:

Dr. Edward S. Williams, internal medicine. Dr. Williams was born in Greenville, N. C. and attended the public schools there. He is a graduate of University of North Carolina and the UNC School of Medicine. He is now completing his residency at North Carolina Memorial Hospital.

Dr. Griggs C. Dickson, pediatrics. Dr. Dickson was born in Garner, N. C., where he attended the public schools. He is a graduate of the University of North Carolina and of the UNC School of Medicine. Dr. Dickson is currently completing his residency at North Carolina Memorial Hospital.

Dr. Charles H. Owens, obstetrics and gynecology. Born in Avondale, N. C., Dr. Owens attended the public schools in Caroleen, N. C. He is a graduate of Davidson College and of the University of North Carolina School of Medicine. He is now completing his residency at North Carolina Memorial Hospital.

Dr. J. C. Parke, Jr., pediatrics. Dr. Parke was reared in Conway, N. C., where he attended the public schools. He is a graduate of University of North Carolina and of the UNC School of Medicine. Dr. Parke is currently serving as a lieutenant in the Navy Medical Corps.

Since the death of Dr. C. M. Scott last June, Hartsville has had only eleven doctors to serve a population estimated at 30,000 to 40,000 in the city's trading area. The trustees and the medical staff of Byerly Hospital have been engaged for some time in an effort to bring more doctors to Hartsville to serve its growing population. Mr. Sory said.

DR. E. FINGER PRESIDENT-NOMINATE

Dr. Elliott Finger was nominated president of the Pee Dee Medical Society at the meeting held recently at the Little Pee Dee Lodge. With Dr. Thomas B. Clark, president, presiding, the following doctors were elected to offices in the society:

Dr. Randy Elvington of Nichols, president-elect; Dr. Ed. Rice of Mullins, vice president; Dr. D. G. Kitchens of Marion, secretary-treasurer; Dr. S. O. Cantey, Jr., of Marion, delegate to the State Convention; Dr. H. S. Gilmore of Nichols, alternate.

Dr. A. S. Pearson, physician of 340 E. Haynes St., was named Spartanburg County "Doctor of the Year" at the annual meeting of the Spartanburg County

Medical Society Monday at the Spartanburg Country Club.

Dr. Allen B. Warren, in presenting the award, cited Dr. Pearson as a "fine physician, a community leader and an example for others in the profession to follow."

Dr. Pearson is a native of Woodruff, a son of the late Cora Wofford Pearson and Basco Pearson. He is a graduate of the Medical College of South Carolina and served his internship at Roper Hospital in Charleston and the Spartanburg hospitals. He has been practicing in Woodruff since 1928.

Dr. Pearson has held every office in the State Foxhunters' Association and is now a vice president of the National Foxhunters' Association.

He is a member and former president of the Woodruff Rotary Club and has been active in the Chamber of Commerce and the First Baptist Church. He is associated with Dr. Lewis Barnett, Jr. at the Medical Center on E. Georgia Street.

OFFICERS NAMED

Dr. J. I. Converse is the new president of the Greenville County Medical Society. Other officers elected Tuesday are president-elect, Dr. Horace Whitworth; vice president, Dr. L. H. Taylor; secretary, Dr. John C. Muller; and treasurer, Dr. Willis S. Hood. Dr. Converse succeeds Dr. Keitt H. Smith as president of the group.

Dr. and Mrs. John A. Workman and children moved to Durham, N. C.

Dr. Workman is studying Anesthesiology at the Duke University Hospital.

Dr. Harwood Beebe has been re-elected chief of staff at Mary Black Hospital. Others elected are Dr. Allan B. Warren, vice chief of staff; Dr. Sam Orr Black, Jr., secretary (re-elected); and Dr. Charles B. Hanna and Dr. Clarence C. Lyles, executive committee members.

ASSOCIATION'S TELEVISION PROGRAM

The medium of television is being used by the South Carolina Medical Association to give South Carolinians an opportunity to hear their community's doctors opinions and to gain a clearer understanding of current medical problems.

Through a series of informal 30-minute programs, "House Call", the doctors reach a diversified audience. This program was presented in the Charleston and Greenville areas in December where it was well received.

The initial program in the series explored the growing problem of medical care and hospitalization of the aged. Future topics for discussion will be "Food Faddism", "Rising Costs of Hospital and Medical Care", "Why Medicine is Organized", and "The Care of the American Executive."

In cooperation with television stations in Charleston, Columbia, Florence, Greenville and Spartanburg the Association plans to produce "House Call" on a monthly basis.

ANNUAL MEETING OF AMERICAN ASSOCIATION FOR THE HISTORY OF MEDICINE TO BE HELD IN CHARLESTON, SOUTH CAROLINA, MARCH 24, 25, 26

Papers on Historical subjects will be presented.

The Scientific sessions are open to anyone who is interested, and the Business and Social activities are open only to members of the Association.

Membership in the Association is $6.00 per year and includes subscription to the Bulletin of the Association for the History of Medicine.

J. I. Waring, Chairman,
Committee on Local Arrangements

The guest speaker for the March Scientific Meeting of the Columbia Medical Society will be Dr. Charles P. Bailey, Philadelphia, Pennsylvania. Dr. Bailey will speak on the subject "Recent Advances in Cardiac Surgery".

The local speaker will be Dr. Buford S. Chappell, who will address the group on "Pyelonephritis".

The meeting will be held at the Columbia Hotel on Monday, March 14, 1960. The social hour will begin at 7:00 P. M., dinner at 7:45, and the scientific session at 8:30 P. M.

All interested physicians are invited to attend.

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia from April 10-12, 1960.

Among the guest speakers will be:

Dr. Harold G. Scheie, Professor of Ophthalmology, University of Pennsylvania.

Dr. Charles E. Iliff, Associate Professor of Ophthalmology, John Hopkins University.

Dr. Oscar T. Becker, Clinical Associate Professor of Otolaryngology, University of Illinois.

For any additional information please contact the secretary, Dr. Albert C. Esposito, First Huntington National Bank Building, Huntington 1, West Virginia.

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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE

DEATHS

DR. C. P. VINCENT

Dr. Charles Pease Vincent, Sr., 76, a practicing physician for 52 years, died early Saturday morning at his home 210 Farley Ave., after several years of declining health.

He was educated at Georgia Military Academy, the Medical College of South Carolina and the University of Maryland Medical School, from which he was graduated in 1907.

Dr. Vincent had practiced medicine for 52 years in Tryon, N. C., Enoree, Sanford, Fla., and Laurens. He came to Laurens in 1914. He had been Laurens County physician for 37 years until his retirement from that post several years ago.

In 1957 Dr. Vincent was presented a Certificate of Appreciation by the University of Maryland Medical School in recognition of his 50 years of service as a physician.

DR. THOMAS B. HARPER

Dr. Thomas Bailey Harper of St. Stephen died January 6, 1960 after a brief illness. He was 64 years old.

Dr. Harper was a native of Kingstree. He was born July 10, 1895.

He was a member of the South Carolina Medical Association, the Berkeley Medical Society, the American Medical Association, and was president of the St. Stephen Lions Club. He was a Mason, and a member of St. Stephen's Protestant Episcopal Church.

Dr. Harper was vice-chairman of the board of the South Carolina Penitentiary System, and served under five governors on the board for about 15 years.

DR. A. C. BAILEY

Dr. A. C. Bailey, 94, a retired physician who was born in upper Greenville County, South Carolina, where he practiced medicine as a young doctor, died after a serious illness of two months.

After practicing for several years in Greenville County, he went to Nashville, Tenn.

He was one of the older physicians in Nashville, where he also was a Shriner and member of many organizations.

BOOK REVIEWS

BIOPSY MANUAL: James D. Hardy, M. D., James C. Griffin, Jr., M. D. and Jorge A. Rodriguez, M. D., W. B. Saunders Co., Philadelphia, 1959. Price $6.50.

This manual describes the principles and technique of biopsy and is arranged by organ systems. It is generously and simply illustrated with pen and ink drawings. The material presented should be of definite value to interns and surgical residents who are beginning to do biopsies. In general, the text is admirably concise, but in some areas the instructions are too incomplete for the beginner. For example, the paragraph concerning needle biopsy of the kidney amounts to a mere statement that such procedures are done. Space devoted to therapy, when unrelated to the problems of biopsy, should be conserved for more complete discussion of the primary topic. In most sections there seems to be a clear concept of the problems of the pathologist, but there are exceptions to this generality. Few pathologists, for example, would want to examine the kind of muscle biopsy recommended. After shrinkage it would be virtually impossible to get a good longitudinal and transverse section. In summary, then, this small book should be useful for teaching the fundamentals of biopsy technique but it can be improved when the authors are ready to prepare a second edition.

Forde A. McIver, M. D.

A MEDICAL HISTORY OF GREENVILLE SOUTH CAROLINA. By J. Decherd Guess, M. D. Printed by Keys Printing Co., Greenville, S. C.: 1959. Price $5.00.

(The book may be ordered from Dr. Willis Hood, Treasurer, Greenville Medical Society, 107 East North St., Greenville, S. C.)

The *Journal* has already taken account of this excellent history of Greenville medicine in its editorial columns. It can be recommended to anyone who has an interest in the area and in the affairs of the South Carolina Medical Association. It is in pleasing format, well written, and altogether an agreeable production.

JIW

NOW OR NEVER, THE PROMISE OF THE MIDDLE YEARS. 1st Ed. By Smiley Blanton, M. D. with Arthur Gordon. 273 pages. Prentice Hall, New Jersey. 1959. Price $4.95.

This book, written for the layman, is primarily a plea for self-evaluation in the "middle years of life." A discussion of difficulties in adjusting to marriage, religion, work, sex, etc. is taken up chapter by chapter and common sense answers proposed. Numerous case histories are utilized explaining the background of many of the everyday problems that beset the average individual and an attempt made to help the person better adjust to, and control them.

Dr. Blanton has long been interested in mental hygiene, and has worked with Norman Vincent Peale in solidifying the bonds between psychiatry and religion. This book is an extension of this work and a "review of forty years of psychiatric counselling."

It is not recommended for the medical profession, but might be of value to some selected patients.

Charlton deSaussure, M. D.

UPPER DIGESTIVE TRACT. Part One of Volume III (Digestive System). Frank H. Netter, M. D. Commissioned and published by Ciba. New York, 1959. $12.50.

This 206 page book is the fourth of a series by the renowned medical artist Dr. Frank H. Netter. Like its predecessors, it is beautifully printed and contains 172 full-color plates which portray the major anatomy, diseases, functional and diagnostic aspects of the upper intestinal tract, including the mouth, pharynx, esophagus, stomach and duodenum.

The descriptive text accompanying Dr. Netters' plates were prepared with the assistance of nine highly regarded medical authorities. A subject index and bibliographic references are included.

To this reviewer's mind this is a highly desirable and valuable book. The art work by Dr. Netter is beautifully done, yet realistic and accurate in every detail. In conjunction with the text, each page is a treasure of information for study, for review, for teaching, or even for use in patient explanations.

The Ciba Pharmaceutical Company publishes these books and makes them available at cost. The book is worth two or three times its price, and Ciba is to be congratulated on this series of works which fill a unique place in medical publications.

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